

DOCKET

No. 88-599-CSX
Status: GRANTED

Title: Washington, et al., Petitioners
v.
Walter Harper

Docketed:
October 5, 1988

Court: Supreme Court of Washington

Counsel for petitioner: Williams, William L.

See also:
88-6525

Counsel for respondent: Phillips, Brian Reed

Entry	Date	Note	Proceedings and Orders
1	Oct 5 1988	G	Petition for writ of certiorari filed.
2	Nov 8 1988		DISTRIBUTED. November 23, 1988
3	Nov 21 1988	F	Response requested -- TM.
4	Dec 23 1988		Order extending time to file response to petition until January 21, 1989.
5	Jan 23 1989		Brief of respondent Walter Harper in opposition filed.
6	Jan 23 1989	G	Motion of respondent for leave to proceed in forma pauperis filed.
7	Jan 25 1989		REDISTRIBUTED. February 17, 1989
8	Feb 2 1989	X	Reply brief of petitioners Washington, et al. filed.
10	Feb 27 1989		REDISTRIBUTED. March 3, 1989
11	Mar 6 1989		Motion of respondent for leave to proceed in forma pauperis GRANTED.
12	Mar 6 1989		Petition GRANTED. *****
13	Mar 21 1989	G	Motion of respondent for appointment of counsel filed.
14	Mar 27 1989		DISTRIBUTED. March 31, 1989. (Motion of respondent for appointment of counsel).
15	Apr 3 1989		Motion for appointment of counsel GRANTED and it is ordered that Brian Reed Phillips, Esquire, of Everett, Washington, is appointed to serve as counsel for the respondent in this case.
17	Apr 6 1989		Order extending time to file brief of petitioner on the merits until May 10, 1989.
18	Apr 18 1989		Joint appendix filed.
19	May 8 1989		Record filed.
21	May 10 1989	*	Certified copy of original record received.
21	May 10 1989		Brief amicus curiae of Washington Community Mental Health Council, et al. filed.
22	May 10 1989		Brief amici curiae of American Psychiatric Assn., et al. filed.
23	May 10 1989		Brief amicus curiae of United States filed.
24	May 10 1989		Brief of petitioners Washington, et al. filed.
25	May 10 1989		Brief amicus curiae of California filed.
26	May 23 1989	G	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
28	May 30 1989		Order extending time to file brief of respondent on the merits until June 30, 1989.
29	Jun 5 1989		Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
30	Jun 28 1989		Brief amicus curiae of American Psychological Assn. filed.

Entry	Date	Note	Proceedings and Orders
31	Jun 29 1989	Brief amici curiae of Natl. Assn. of Protection and Advocacy Systems, et al. filed.	
37	Jun 29 1989	Brief amicus curiae of Coalition for Fundamental Rights and Equality of Ex-Patients filed.	
32	Jun 30 1989	Brief amici curiae of Mental Health Legal Advisors Comm. of MA, et al. filed.	
33	Jun 30 1989	Brief amicus curiae of New Jersey Dept. of Public Advocate filed.	
34	Jun 30 1989	Brief of respondent Walter Harper filed.	
35	Jul 20 1989	SET FOR ARGUMENT WEDNESDAY, OCTOBER 11, 1989. (3RD CASE)	
36	Jul 24 1989	Lodging received. (10 copies).	
38	Jul 27 1989	CIRCULATED.	
39	Aug 2 1989	X Reply brief of petitioners Washington, et al. filed.	
40	Oct 11 1989	ARGUED.	

**PETITION
FOR WRIT OF
CERTIORARI**

88-599⁽¹⁾

Supreme Court, U.S.

FILED

OCT 5 1988

JOSEPH F. SPANIOLO,
CLERK

No. _____

IN THE
SUPREME COURT
OF THE
UNITED STATES

OCTOBER TERM, 1988

STATE OF WASHINGTON, et al.,

Petitioners,

v.

WALTER HARPER,

Respondent.

PETITION FOR A WRIT OF CERTIORARI
TO THE SUPREME COURT OF
THE STATE OF WASHINGTON

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43122

QUESTION PRESENTED

I. Is an incarcerated felon constitutionally entitled to a judicial hearing and attendant adversarial procedural protections prior to the involuntary administration of medically prescribed antipsychotic medication?

II. If an incarcerated felon possesses a constitutionally protected liberty interest in refusing medically prescribed antipsychotic medication, must the State prove a compelling state interest to administer antipsychotic medication or does the "reasonable relation" standard of *Turner v. Safley*, ___ U.S. ___ 107 S. Ct. 2254, 96 L.Ed.2d 64 (1987), control?

LIST OF PARTIES

The parties to the proceeding below were: Petitioners, State of Washington; Joseph Lehman, former Assistant Director of the Washington State Division of Prisons, now Director of the Division of Prisons of the Department of Corrections; Kenneth DuCharme, Superintendent, Washington State Reformatory; Herbert Marra, former Superintendent of the Washington State Special Offender Center; John Petrich, a consulting psychiatrist to the Washington State Special Offender Center; Tom Rolfs, former Superintendent of the Washington State Special Offender Center; William Stark, former Associate Superintendent of the Washington State Special Offender Center; Phillip Giles, Ph.D.; Janiese Loken, M.D.; M.C. Storrie-Lumbardi, M.D.; all of the Washington State Special Offender Center. The above parties were aligned as Defendants-Respondents below.

Respondent Walter Harper, an inmate serving a sentence in the Washington State Prison system, was aligned as the Plaintiff-Appellant below.

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No. _____

IN THE

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OF THE

UNITED STATES

OCTOBER TERM, 1988

STATE OF WASHINGTON, et al.,

Petitioners,

v.

WALTER HARPER,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE WASHINGTON STATE SUPREME COURT

The Petitioners respectfully pray that a Writ of Certiorari issue to review the judgment and opinion of the Washington State Supreme Court, filed on July 7, 1988.

OPINIONS BELOW

The decision of the Washington State Supreme Court has not yet been reported. It is reprinted hereto as Appendix A. The findings of fact and conclusions of law of the trial court below are attached as Appendix B.

JURISDICTION

The Washington State Supreme Court filed an opinion on July 7, 1988, reversing the Snohomish County Superior Court's decision dismissing Respondent's 42 U.S.C. § 1983 complaint. The Washington State Supreme Court remanded

the case to the lower court to consider the claims for injunctive and declaratory relief and to address state law issues.

Petitioners invoke this Court's jurisdiction to review the opinion of the Washington State Supreme Court pursuant to 28 U.S.C. § 1257(3).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Fourteenth Amendment to the United States Constitution, section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

42 U.S.C. § 1983. Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

STATEMENT OF THE CASE

Respondent Harper is a felon incarcerated in the Washington State Department of Corrections.¹ In February 1985, Harper filed a complaint in Snohomish County Superior Court, pursuant to 42 U.S.C. § 1983. Harper sought injunctive, declaratory, and monetary relief from the State of Washington and the individually named defendants. Harper also alleged state law violations. Appendix A, pp. 3-4.

¹ The underlying facts were undisputed and are contained in Appendix B, the state trial court findings of fact, and are discussed in Appendix A, the opinion of the Washington State Supreme Court.

Harper's § 1983 action was based on alleged violations of the due process and equal protection clauses of the state and federal constitutions, due to the administration to him of antipsychotic medications pursuant to the Special Offender Center's involuntary medication policy.² Appendix B, p. 2.

The defendants contended that the administrative hearing process which was conducted prior to involuntarily medicating Harper was constitutional and that their actions were privileged. Appendix B, p. 2.

The trial court found that Harper had a constitutionally protected liberty interest in not being involuntarily subjected to treatment with antipsychotic medications without due process. However, the trial court found that the challenged involuntary medication policy adequately protected Harper's liberty interest and complied with constitutional requirements. The trial court found that the challenged policy was consistent with the due process requirements of the federal constitution as established in *Vitek v. Jones*, 455 U.S. 480 (1980). The trial court dismissed the complaint with prejudice and entered a decision in favor of the defendants. Appendix B, pp. 8-9.

Respondent Harper appealed directly to the Washington Supreme Court. On appeal, Harper did not dispute that the involuntary medication policy was complied with. He contended however that the policy failed to provide adequate due process protection because it allowed antipsychotic medication to be administered against his will without a judicial hearing.³ Appendix A, p. 4.

The Washington Supreme Court agreed that Harper had a protected liberty interest in refusing antipsychotic treatment. Appendix A, p. 4. As to the procedural due proc-

² The Special Offender Center is a correctional institution administered by the Washington State Department of Corrections. The Special Offender Center was established to provide diagnosis and treatment of convicted felons having serious behavioral or mental disorders. Appendix A, p. 3. The medication policy is discussed at length in the trial court's findings of fact, Appendix B at pp. 3-4 and in the opinion of the Washington Supreme Court, Appendix A, pp. 6-8.

³ The Washington Supreme Court decided the case on due process grounds, thus, it did not address Harper's equal protection or free speech claims. Appendix A, p. 4. n. 2.

ess issue, the Washington Supreme Court held, on constitutional grounds, that a judicial hearing is required prior to the administration of antipsychotic drugs to a prisoner against his will, and that Harper's § 1983 claim was valid.⁴ Appendix A, pp. 8-9, 13.

To find a due process violation, the Washington Supreme Court rejected petitioner's argument that the standards of *Vitek v. Jones*, 445 U.S. 480 (1980), were met if a hearing was conducted by an independent decisionmaker (not necessarily a judge) with appropriate procedural protections.⁵ The Washington Supreme Court also rejected petitioner's argument that *Youngberg v. Romeo*, 457 U.S. 307 (1982) established a "professional judgment" standard which allowed the involuntary administration of antipsychotic medications if done pursuant to the professional judgment of a medical professional. Appendix A, pp. 8-9.

The Washington State Supreme Court held that the state must prove a compelling state interest to administer antipsychotic drugs by a "clear, cogent, and convincing" standard of evidence, as well as other procedural protections. Appendix A, pp. 10-11.

Finally, the Washington State Supreme Court ruled that the defendants were entitled to qualified immunity from damages and remanded the case for proceedings consistent with the opinion. *Id.* at pp. 12-13.

SUMMARY OF ARGUMENT

This Court should review the decision of the Washington State Supreme Court. That decision erroneously held that an incarcerated felon is constitutionally entitled to a judicial hearing prior to the involuntary administration of

⁴ The trial court found that state and federal constitutional requirements were met. The Washington State Supreme Court did not precisely describe the origin of the constitutional right. However, since a successful 42 U.S.C. § 1983 action requires a violation of the federal Constitution or a federal statute, the Washington State Supreme Court's holding was necessarily based on federal constitutional grounds.

⁵ *Vitek v. Jones*, 445 U.S. 480 (1980), did not require a judicial hearing, legal counsel nor unlimited rights to call witnesses, confront witnesses, or cross examine. *Id.* at 496. Each of these is required under the Washington Supreme Court's decision. Appendix A, pp. 8-11.

medically prescribed antipsychotic medication. The decision ignores the "professional judgment" standard established in *Youngberg v. Romeo*, 457 U.S. 307 (1982).

While creating a new fundamental right, the Washington State Supreme Court is in conflict with the analysis of the federal courts of appeal in various circuits and this Court's decisions in *Youngberg* and *Vitek v. Jones*, 445 U.S. 480 (1980).

The Washington State Supreme Court also refused to follow this Court's holding in *Turner v. Safley*, ___ U.S. ___, 107 S. Ct. 2254, 96 L.Ed.2d 64 (1987) which dictates that a prisoner's fundamental rights are protected by a "reasonable relation" analysis.

The effect of the Washington State Supreme Court's decision will be to insert the state and federal judicial systems into medical and institutional administrative decisions involving civil committees and incarcerated felons, in violation of this Court's repeated teachings.

This Court, therefore, should accept review, not only to rectify an erroneous decision in contravention of this Court's pronouncements and in conflict with circuit courts of appeal, but also to provide guidance to lower courts struggling with burgeoning § 1983 litigation.

REASONS FOR GRANTING THE WRIT

I. The Washington State Supreme Court erroneously held that an incarcerated felon is constitutionally required to receive a judicial hearing prior to the involuntary administration of antipsychotic medication prescribed by a qualified psychiatrist. This rule is in conflict with the "professional judgment" standard utilized by the federal courts of appeal following this Court's direction.

While the Washington State Supreme Court's decision is only binding on the Washington State judicial system, if it is relied upon by federal courts or other state courts, it presents an issue that will affect the administration of psychiatric care in every jail, prison, and psychiatric treatment

facility.⁶ The Washington State Supreme Court's holding that a judicial hearing must be held prior to the involuntary administration of antipsychotic medication is in direct conflict with decisions of the federal circuit courts and of this Court.

In *Vitek v. Jones*, 445 U.S. 480 (1980) the Court addressed the constitutionally required⁷ procedural due process protections implicated when an inmate suffers the stigmatizing consequences of transfer to a mental hospital where he would be subjected to mandatory behavior modification as a treatment for mental illness. *Id.* at 491-492.

The *Vitek* Court found that the following procedural due process protections afforded sufficient protection against classifying a convicted felon as mentally ill and subjecting him to involuntary treatment:

"A. Written notice to the prisoner that a transfer to a mental hospital is being considered;

"B. A hearing, sufficiently after the notice to permit the prisoner to prepare, at which disclosure to the prisoner is made of the evidence being relied upon for the transfer and at which an opportunity to be heard in person and to present documentary evidence is given;

"C. An opportunity at the hearing to present testimony of witnesses by the defense and to confront and cross-examine witnesses called by the state, except upon a finding, not arbitrarily made, of good cause for not permitting such presentation, confrontation, or cross-examination;

"D. An independent decisionmaker;

"E. A written statement by the factfinder as to the

⁶ The *Harper* decision on its face deals with the right of an incarcerated felon to refuse medically prescribed antipsychotic medication. The decision however does not by its terms limit the court's holding to that context. Further, it is undeniable that persons who are not incarcerated felons have rights at least coextensive with those of incarcerated felons. Thus, there is no doubt that the court's decision applies to civil committees under Washington's Involuntary Treatment Act — RCW 71.05 — and in fact it is being so applied. See, for example, the *Seattle Times* September 9, 1988 newspaper article describing the effect of the *Harper* decision on civil committees. Appendix C.

⁷ The *Vitek* Court agreed that the lower court had properly "avoided unnecessary intrusion into either medical or correctional judgments by providing that the independent decisionmaker conducting the transfer hearing need not come from outside the prison or hospital administration." *Vitek* at 497.

evidence relied on and the reasons for transferring the inmate;

"F. Availability of legal counsel, furnished by the state, if the inmate is financially unable to furnish his own; and

"G. Effective and timely notice of all the foregoing rights."

Vitek at 494-495.

In the instant case, the trial court held that the Special Offender Center's involuntary medication policy was consistent with the *Vitek* requirements and met constitutional standards. Appendix B, p. 9. The Washington State Court disagreed, finding *Vitek* inapplicable, Appendix A, pp. 7-8.

The Washington State Supreme Court concluded that the *Vitek* Court was concerned with the "stigmatizing consequences" of a transfer to a mental health hospital for involuntary psychiatric treatment. The *Harper* court distinguished the *Vitek* procedural requirements due to the more intrusive nature of antipsychotic drug treatment. Appendix A, pp. 7-8. However, the *Vitek* Court found the procedural protections of *Vitek* were required due to the coupling of the "stigmatizing consequences" of the transfer with mandatory behavior modification. *Vitek* at 488, 494. More importantly, the record before the *Vitek* Court "appeared" to include medication. See *Miller v. Vitek*, 437 F. Supp. 569, 571, n.8 (D. Neb. 1987). Whether or not the mandatory behavior modification the *Vitek* Court was concerned with included behavior modifying medication, it is clear that the *Vitek* Court found its procedural due process requirements sufficient to protect against "involuntary psychiatric treatment." *Vitek* at 494. Thus the State Supreme Court's effort to distinguish *Vitek* is misplaced and misleading.

The "professional judgment" standard was utilized in the context of an involuntarily committed patient's rights regarding issues including freedom from bodily restraints in *Youngberg v. Romeo*, 457 U.S. 307, 309 (1982). In *Youngberg*, the Court adopted the "professional judgment" standard to provide guidance to reflect the proper balancing of legitimate state interests and the rights of the involuntarily committed. *Youngberg* at 322. The *Youngberg* Court agreed with the federal trial court judge that "the Constitution only requires

that the courts make certain that professional judgment, in fact, was exercised. It is not appropriate for the courts to specify which, of several professionally acceptable choices, should have been made." *Youngberg* at 321. The *Youngberg* Court also explained that the professional judgment standard is a lower one than a "compelling" or "substantial" necessity test. *Id.* at 322. The Court found that a compelling or substantial necessity test would place an undue burden on the administration of an institution and would also unnecessarily restrict the exercise of professional judgment. *Id.*

In determining what the Constitution reasonably requires, the *Youngberg* Court also emphasized the need to show deference to qualified professional judgment, noting that by so limiting judicial review, interference by the federal judiciary with institutional operation would be minimized. *Id.* Further, the *Youngberg* Court reiterated that "there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions." *Youngberg* at 322-323, citing *Parham v. J.R.*, 442 U.S. 584, 607 (1979).

Contrary to the Court's decision in *Youngberg*, the rule established by the Washington State Supreme Court in *Harper* will often require the judiciary to decide which of several professionally acceptable choices should be made. The court below specifically provided that the court may make a "substituted judgment" decision for the patient as well as placing time limits and conditions upon the administration of medication. Appendix A, p. 11. In addition, contrary to the *Youngberg* decision that a compelling or substantial necessity test is improper, the court below required that the state prove a compelling state interest to administer antipsychotic drugs. Appendix A, p. 11.

There can be no doubt but that the plunging of the judicial system into medical and administrative institutional decision-making will burden both the institutions and the judicial system. This is clearly contrary to the direction of the *Youngberg* and *Parham* Courts. *Youngberg* at 321, n. 29.

It may be argued that *Youngberg* is distinguishable from the present case due to the fact that *Youngberg* did not specifically address the involuntary administration of antipsychotic medication. However, it is clear by the Court's

action subsequent to *Youngberg*, that the Court intended the "professional judgment" standard to apply to an involuntarily committed individual's right to refuse antipsychotic medication. In *Rennie v. Klein*, 458 U.S. 1119 (1982), the Court remanded the case in light of *Youngberg*. On remand, the Third Circuit held that a judicial hearing was not required prior to the nonconsensual administration of antipsychotic medication to involuntarily committed mental patients. While utilizing the *Youngberg* rationale, the *Rennie* court found that the administrative procedures adopted by New Jersey, which required a review by mental health professionals to determine whether a patient is a danger to himself or others, and therefore in need of drug therapy, were adequate to protect the patient's Constitutional rights. *Rennie v. Klein*, 720 F.2d, 266, 269 (3rd Cir. 1983).

The action of the United States Supreme Court in remanding *Rennie* in light of *Youngberg*, has resulted in the "professional judgment" standard being adopted in other circuits.

Regarding an involuntarily committed individual's right to refuse treatment with antipsychotic medication, the Second Circuit concluded that the United States Supreme Court's action in remanding *Rennie v. Klein* in light of *Youngberg* mandated the application of the "professional judgment" standard. *Project Release v. Prevost*, 722 F.2d 960, 980 (2nd Cir. 1983). The Second Circuit did find that due process requires an opportunity for a hearing and a review of a decision to administer antipsychotic medication, but that such a hearing need not be judicial in nature. *Id.* at 981.

The Fourth Circuit has also concluded that the *Youngberg* "professional judgment" standard must be shown to have been violated in order for a defendant who has been required to take antipsychotic medication to prevail. *Johnson v. Silvers*, 742 F.2d 823, 825 (4th Cir. 1984). The *Johnson* case involved an involuntarily committed patient in a mental institution.

The Eighth Circuit has also relied on *Youngberg v. Romeo*, to conclude that the due process requirements of the Fourteenth Amendment were not violated when hospital officials administered psycho-therapeutic drugs to a mental

ward patient against his will. *Dautremont v. Broadlawns Hosp.*, 827 F.2d 291, 300 (8th Cir. 1987). The *Dautremont* court found that the key language in the United States Supreme Court decision in *Youngberg* regarding liberty from bodily restraint was the reference to interests "protected by the due process clause from arbitrary governmental action" (emphasis added). The *Dautremont* court found that since the record in the case indicated that the decision to administer the psycho-therapeutic drugs was made by professionals exercising professional judgment, and not arbitrarily, federal constitutional requirements were met. *Id.* at 300.

The circuit cases discussed above clearly indicate that the "professional judgment" standard sufficiently protects the constitutional rights of civilly committed persons; *a fortiori*, the "professional judgment" standard adequately protects incarcerated felons. "Persons who have been involuntarily committed are entitled to more considerate treatment than criminals whose conditions of confinement are designed to punish." *Youngberg* at 321, 322.

Moreover, the "professional judgment" standard has been found to apply to incarcerated inmates as well as civil committees who are involuntarily administered antipsychotic medication. In *U.S. v. Bryant*, 670 F. Supp. 840 (D. Minn. 1987) the court concluded that a court should not specify which of several professional choices should have been made in administering such a medication program. The *Bryant* case, involving an incarcerated inmate, was decided prior to the Eighth Circuit's decision in *Dautremont*, *supra* and thus correctly anticipated that decision. The *Bryant* court came to this conclusion in reliance upon *Youngberg*, *Project Release v. Prevost*, and *Johnson v. Silvers*, *supra*. *Bryant* at 844. *Bryant* illustrates that the "professional judgment" standard properly applies to incarcerated inmates as well as civil committees.

The above cases show that the circuits have indeed adopted the *Youngberg* "professional judgment" standard, and that the decision of the Washington State Supreme Court, which decided that the Constitution required judicial intervention, is in conflict with the courts of appeal.

Assuming that an incarcerated felon does possess a constitutionally protected liberty interest in refusing antipsy-

chotic medication, petitioners assert that the Washington State Supreme Court erroneously concluded that the state must show a "compelling state interest" to administer antipsychotic drugs. Appendix A, p. 10.

In *Turner v. Safley*, ___ U.S. ___, 107 S.Ct. 2254, 96 L.Ed.2d 64 (1987), the Court analyzed decisions involving inmates' rights and concluded that the proper standard of scrutiny for a prison regulation that burdens fundamental rights is "whether * * * [the] regulation that burdens fundamental rights is 'reasonably related' to legitimate penological objectives, or whether it represents an 'exaggerated response' to those concerns." *Id.* at 2260-2261. The *Turner* Court held that "when a prison regulation impinges on inmate's constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests." *Id.* at 2661. The *Turner* Court found such a standard to be necessary "if prison administrators * * *, and not the courts [are] to make the difficult judgment concerning institutional operations." *Turner* at 2261, quoting *Jones v. North Carolina Prisoners Union*, 433 U.S. 119, 128 (1977).

The *Turner* Court was concerned with first amendment issues, an area traditionally scrutinized rigorously and in which individual rights are fiercely protected. Nonetheless, the *Turner* Court used very broad language which indicates the Court intended the "reasonable relation" analysis to apply to the scrutiny of all prison policies. See *Turner* at 2261.

The case at bar presents the question of whether the *Turner* "reasonable relation" analysis should apply in examining the constitutionality of an involuntary medication policy. The circuit courts of appeals have applied the "reasonable relation" analysis in contexts other than the first amendment context involved in *Turner v. Safley*, *supra* and the companion case of *O'Lone v. Estate of Shabazz*, ___ U.S. ___, 107 S.Ct. 2400, 96 L.Ed.2d 282 (1987). See *Kent v. Johnson*, 821 F.2d 1220 (6th Cir. 1987) (first, fourth, eighth, and fourteenth amendment contexts) and *Zimmerlee v. Keeney*, 831 F.2d 183, 186 (9th Cir. 1987) (fourteenth amendment context). The court below, in contrast, rejected the "reasonable relation" analysis in the instant case. Appendix A, p. 10, n.a. There is no principled reason why that analysis should not apply here as well.

2. The effect of the decision of the Washington State Supreme Court will be to increase involvement by the state and federal judicial systems in medical decisions involving the administration of antipsychotic medications to state and federal convicted prisoners, and civilly committed persons.

The decision of the Washington Supreme Court which found that a constitutionally protected fundamental liberty interest in refusing antipsychotic medication must be protected by a judicial hearing, will have wide-ranging impact. Although the *Harper* facts involved an individual convicted of a felony under Washington State law, the decision will also apply to pretrial detainees, federally convicted inmates, and civil committees.

As to pretrial detainees, this Court has indicated that "pretrial detainees, who have not been convicted of any crimes, retain at least those constitutional rights that we have held are enjoyed by convicted prisoners." *Bell v. Wolfish*, 441 U.S. 520, 545 (1979).

Similarly, it is axiomatic that civil committees, whether voluntary or involuntary, are entitled to at least the constitutional protections of persons convicted of a crime. Also, since the Washington Supreme Court's decision is constitutionally grounded, *a fortiori*, it will apply to federal prisoners housed in state facilities. Washington currently houses over 700 federal inmates.

The requirement of a judicial hearing prior to the administration of antipsychotic medication will enmesh the state and federal judicial systems in the daily medical decisions made by professionals administering prisons, hospital facilities and state mental health institutions. This involvement is contrary to repeated teachings of this Court. The following observations from *Youngberg* succinctly illustrate the Court's view regarding such judicial involvement:

In limiting judicial review of medical decisions made by professionals, "it is incumbent on courts to design procedures that protect the rights of the individual without unduly burdening the legitimate efforts of the states to deal with difficult social problems" [citing *Parham v. J.R.*, 442 U.S. 584, 608, n.16, (1979)];

"[C]ourts cannot assume that state legislatures and prison officials are insensitive to the requirements of the

Constitution or to the perplexing sociological problems of how best to achieve the goals of the penal function in the criminal justice system * * * [citing *Rhodes v. Chapman*, 452 U.S. 337, 352 (1981)];

In the context of conditions of confinement of pretrial detainees, "[c]ourts must be mindful that these inquiries spring from constitutional requirements and that judicial answers to them must reflect that fact rather than a court's idea of how best to operate a detention facility" [citing *Bell v. Wolfish*, 441 U.S. 520, 539 (1979)];

In considering a procedural due process claim in the context of prison, "there must be mutual accommodation between institutional needs and objectives and the provisions of the Constitution that are of general application" [citing *Wolff v. McDonnell*, 418 U.S. 539, 556 (1974)].

Youngberg at 322, n.29.

The effect of the *Harper* Court's discovery of a constitutionally required judicial hearing prior to the involuntary administration of antipsychotic medications, will be to entangle the courts of this nation in judgments this Court has indicated are best made by medical professionals in concert with qualified institutional administrators.

CONCLUSION

For all of the foregoing reasons, the Writ of Certiorari should be granted.

DATED this 29th day of September, 1988.

Respectfully submitted,

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APPENDIX A

[No. 54045-4. En Banc.]

WALTER HARPER,

Appellant,

v.

THE STATE OF WASHINGTON,

Respondent.

- [1] Prisons — Mental Health — Prison Inmate — Involuntary Administration of Antipsychotic Drugs — Liberty Interest. A prisoner has a fundamental liberty interest in refusing treatment with antipsychotic drugs.
- [2] Prisons — Mental Health — Prison Inmate — Involuntary Administration of Antipsychotic Drugs — Judicial Hearing — Burden and Degree of Proof. When the State desires to administer antipsychotic drugs to a prisoner against his will, a judicial hearing must be held at which the State has the burden of establishing by clear, cogent, and convincing evidence that the administration of the drugs is both necessary and effective to further a compelling state interest. The prisoner is entitled to due process protections, including reasonable notice and time to prepare for the hearing, the right to attend the hearing and be represented by an attorney, and other constitutional safeguards applicable to criminal trials.
- [3] Civil Rights — Deprivation — Immunity — State — New Constitutional Right. The State is immune from liability under the 42 U.S.C. § 1983 for its violation in good faith of a person's constitutional right that was not clearly established at the time of the violation.

Nature of Action: A prisoner who had been injected against his will with antipsychotic drugs sought injunctive, declarative, and monetary relief.

Superior Court: The Superior Court for Snohomish County, No. 85-2-00394-1, Daniel T. Kershner, J., entered a judgment in favor of the State on May 21, 1987.

Supreme Court: Holding that the prisoner was entitled to a judicial hearing before the administration of the drugs but that the State was immune from damages under 42

U.S.C. § 1983 for violating the prisoner's civil rights, the court *reverses* the judgment and *remands* the case for further proceedings.

Brian Reed Phillips, for appellant.

Kenneth O. Eikenberry, Attorney General, and *Glenn L. Harvey*, Assistant, for respondent.

John H. Hertog, Jr., and *Neil R. Sarles* on behalf of the American Civil Liberties Union; *James F. Pultz* and *Robert A. Stalker, Jr.*, on behalf of Evergreen Legal Services and Institutional Legal Services; *William Salen* and *George Yeannakis* on behalf of Seattle-King County Public Defender Association, amici curiae for appellant.

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IN THE SUPREME COURT OF
THE STATE OF WASHINGTON

No. 54045-4 En Banc

WALTER HARPER,

Appellant,

v.

STATE OF WASHINGTON,

Respondent.

FILED: Jul 07 1988.

BRACHTENBACH, J. — Is a prisoner entitled to a judicial hearing before antipsychotic drugs can be administered against his will? The trial court answered no. We accepted direct review and reverse.

The facts are undisputed. Convicted of robbery, appellant Harper was sentenced in 1976 to the Washington State Penitentiary in Walla Walla. Between 1976 and 1980, Harper was housed primarily in the mental health unit there, where he voluntarily underwent antipsychotic drug therapy. Harper was transferred periodically to Eastern State Hospital for evaluation and treatment.

Harper was paroled in 1980 on condition that he participate in psychiatric treatment. He spent some of his parole

time in the psychiatric ward at Harborview Medical Center in Seattle, and part at Western State Hospital, pursuant to a civil commitment order. In December 1981, Harper's parole was revoked after he assaulted two nurses at Saint Cabrini Hospital in Seattle.

Following his return to prison, Harper was sent to the Special Offenders Center (SOC) at Monroe in January 1982. The SOC is a 144-bed correctional institution administered by the Department of Corrections. The SOC was established to provide diagnosis and treatment of convicted felons having serious behavioral or mental disorders. Approximately 27 inmates at the SOC receive involuntary medication.

While at the SOC, Harper voluntarily submitted to treatment, including administration of antipsychotic medications. In November 1982, Harper refused to continue taking the prescribed antipsychotic drugs. At Harper's treating physician's request, a hearing committee was convened to determine whether medication should be administered to Harper against his will. Harper does not dispute that the hearing took place in accord with SOC policy. The committee found that, as a result of mental disease or disorder, Harper was a danger to others. The committee authorized Harper's involuntary medication. Harper appealed the decision to the Monroe reformatory superintendent, who upheld the committee's decision.

Between November 1982 and June 1985, Harper was involuntarily medicated with a variety of antipsychotic drugs. During this period, Harper's treatment was reviewed by the committee approximately every 2 weeks. Each time, the committee decided to continue the medications, although the dosages or drugs were sometimes changed.

In February 1985, Harper filed this action for injunctive and monetary relief against the State¹ for its administration of antipsychotic medications to him pursuant to SOC's involuntary medication policy. Harper was not present when the case was heard in superior court. Following trial, the court

¹ Harper brought his claim pursuant to the Civil Rights Act of 1866, 42 U.S.C. § 1983. At trial, he alleged constitutional violations along with tort claims for assault, battery and outrage. See Complaint, at 6-7, Clerk's Papers, at 122-23.

dismissed Harper's complaint. Harper appealed directly to this court.

Harper does not dispute that the State followed the SOC involuntary medication policy. Instead, he contends that the policy fails to provide adequate due process protection because it allows the State to decide to administer antipsychotic medication against his will without a judicial hearing.²

I

Initially, we agree with the trial court's conclusion that Harper had a protected liberty interest in refusing antipsychotic drug treatment.³ See Conclusion of law 1, Clerk's Papers, at 18. We have recognized that competent adults have a right to determine what shall be done to their bodies. *In re Schuoler*, 106 Wn.2d 500, 506, 723 P.2d 1103 (1986); *In re Ingram*, 102 Wn.2d 827, 836, 689 P.2d 1363 (1984); *In re Colyer*, 99 Wn.2d 114, 119, 660 P.2d 738 (1983). We also have specifically recognized a right to refuse electroconvulsive therapy. *In re Schuoler*, *supra*.

In *Schuoler*, the plaintiff was involuntarily committed because of severe mental problems. At her commitment hearing, her treating psychiatrist asked the court to authorize electroconvulsive therapy (ECT), which the plaintiff had refused to undergo. Following a separate hearing on the issue, the trial court authorized ECT. This court reversed, holding that "a person involuntarily committed due to a mental disorder retains a fundamental liberty interest in refusing

² Because we decide this case on due process grounds, we do not address Harper's equal protection or free speech claims.

³ Antipsychotic drugs are also referred to as psychotropic drugs, neuroleptics, and major tranquilizers. See Kemna, *Current Status of Institutionalized Mental Health Patients' Right to Refuse Psychotropic Drugs*, 6 J. Legal Med. 107, 109 (1985); Goodman & Gilman's *The Pharmacological Basis of Therapeutics* 152, 172-74 (6th ed. 1980). This category of drugs commonly includes phenothiazines (e.g., Thorazine, Vesprin, Serenitil Prolixin), thioxanthenes (e.g., Navane) and other heterocyclic compounds (e.g., Haldol). Goodman & Gilman's, *supra*, at 391-408. The drugs administered to Harper included Trialafon, Haldol, Prolixin, Taractan, Loxitane, Mellaril, and Navane. See Finding of fact 9, Clerk's Papers, at 16.

Our holding here applies specifically to this category of drugs.

ECT." *Schuoler*, at 507. We noted that the right to refuse ECT was especially important because ECT is a highly intrusive medical procedure with well documented adverse side effects such as memory loss and impairment of learning ability. See *Schuoler*, at 506.

Like ECT, antipsychotic drug therapy is a highly intrusive form of medical treatment. See *Guardianship of Roe*, 383 Mass. 415, 436-37, 421 N.E.2d 40 (1981). Antipsychotic drugs are by intention mind altering; they are meant to act upon the thought processes. *Riese v. St. Mary's Hosp. and Med. Ctr.*, 196 Cal. App. 3d 1388, 243 Cal. Rptr. 241 (1987); *Guardianship of Roe*, *supra*.

The benefits of antipsychotic drug treatment to acutely ill patients are well documented. See Goodman & Gilman's, *The Pharmacological Basis of Therapeutics* 152, 172-74 (6th ed. 1980). Also documented, however, are the adverse side effects of antipsychotic drug treatment. Less serious, reversible, side effects include dystonia, a severe involuntary spasm of the upper body, throat, tongue or eyes; akathisia, the inability to remain still, restlessness and agitation; and pseudo-Parkinsonism, manifested by a mask-like face, drooling, muscle rigidity, stiffness, tremors and a shuffling gait.⁴ See Findings of fact 9, Clerk's Papers, at 11; Kemna, *Current Status of Institutionalized Mental Health Patients' Right to Refuse Psychotropic Drugs*, 6 J. Legal Med. 107, 111-113 (1985); Goodman & Gilman's, *supra*, at 164-172. Although common, these effects can be controlled by administration of other drugs, adjustment of the dosage, or termination of the therapy. Kemna, at 112; Goodman & Gilman's, at 164-172. Severe and potentially permanent is tardive dyskinesia, an irreversible neurological disorder characterized by involuntary, uncontrollable movements of the tongue, mouth or jaw. Fingers, arms and legs may also be affected. Tardive dyskinesia can be masked by the drug causing the condition, and can manifest itself years after treatment has occurred. See Finding of fact 9, Clerk's Papers, at 11; Kemna, *supra*, at 113.

⁴ The record shows that Harper exhibited symptoms of dystonia and akathisia and was treated with the side effect medication, Cogentin. He did not show signs of tardive dyskinesia. See Finding of fact 10, Clerk's Papers, at 12.

We find that antipsychotic drug treatment is no less intrusive than ECT. Therefore, we recognize a fundamental liberty interest in refusing antipsychotic drug treatment as well. Other courts have reached similar conclusions. *See, e.g., Riese v. St. Mary's Hosp. and Med. Ctr., supra; People v. Medina*, 705 P.2d 961, 967 (Colo. 1985); *Rogers v. Commissioner of Dep't of Mental Health*, 390 Mass. 489, 458 N.E.2d 308 (1983); *Guardianship of Roe, supra* at 436-37 ("few legitimate medical procedures * * * are more intrusive than the forcible injection of antipsychotic medication. * * * Because of both the profound effect that these drugs have on the thought processes * * * and the well-established likelihood of severe and irreversible adverse side effects * * * we treat these drugs in the same manner we would treat psychosurgery or electroconvulsive therapy").

II

The State argues that Harper's liberty interest in refusing treatment was adequately protected by the existing SOC involuntary medication policy. The trial court agreed. *See Conclusion of law 3, Clerk's Papers, at 66.*

The SOC involuntary medication policy provides for a hearing prior to the administration of antipsychotic drugs. *See generally, Finding of fact 3, Clerk's Papers, at 8-11.* Hearings are held before a committee composed of a psychiatrist, a psychologist, and the SOC associate superintendent. *Finding of fact 3(b), Clerk's Papers, at 9.* A prisoner can be medicated against his will if a majority⁵ of the committee finds that he suffers from a mental disorder gravely disabling him or causing him to present a likelihood of serious harm to himself or others. *Finding of fact 3(a), Clerk's Papers, at 9.*

The policy grants the following procedural protections: 24-hour notice of the SOC's intent to convene an involuntary medication hearing; the right to be present and to present evidence, including witnesses; the right to cross-examine the staff witnesses; the assistance of a lay advisor; the right to appeal the decision to the SOC superintendent; and the right

⁵ If medication is approved, the psychiatrist must vote with the majority. *Finding of fact 3(b), Clerk's Papers, at 9.*

to periodic reviews subsequent to the initial hearing. *Finding of fact 3, Clerk's Papers, at 8-11.*

The policy does not allow representation by counsel. *Finding of fact 7, Clerk's Papers, at 14.* The rules of evidence do not apply. The policy does not provide for review of the committee's decision, except by personal restraint petition or extraordinary writ to the superior court. *See Conclusion of law 2, Clerk's Papers, at 18.* Also, although a prisoner's treating physician who has recommended the involuntary medication cannot sit on the initial committee, he can sit on subsequent panels reviewing continued treatment if he is at that time no longer the treating physician, creating a conflict of interest the policy apparently meant to avoid. *See Findings of fact 6, 7, Clerk's Papers, at 13-15.*

Prior to an involuntary medication hearing, committee members consult with the SOC staff outside the presence of the prisoner to determine whether policy requirements have been met and what the staff's position will be at the hearing. *Finding of fact 7, Clerk's Papers, at 14.* Staff members then summarize their positions for the hearing committee and briefly present their reasons as to why the prisoner is dangerous and why his condition is a product of a mental disorder. *Finding of fact 7, Clerk's Papers, at 14.* The prisoner is brought into the hearing, which then proceeds in accordance with policy. *Finding of fact 7, Clerk's Papers, at 14.* The prisoner is excused during the committee's deliberations, after which the prisoner is brought back in and informed of the committee's decision. *Finding of fact 7, Clerk's Papers, at 14.* The committee later dictates its final decision and findings. *Finding of fact 7, Clerk's Papers, at 14-15.*

The State contends that no judicial hearing is required, urging that a decision based on professional judgment adequately protects prisoners' rights to refuse antipsychotic drug treatment.

The State relies on *Vitek v. Jones*, 445 U.S. 480, 495, 63 L. Ed. 2d 552, 100 S. Ct. 1254 (1980); *Youngberg v. Romeo*, 457 U.S. 307, 73 L. Ed. 2d 28, 102 S. Ct. 2452 (1982); and *Large v. Superior Court*, 148 Ariz. 229, 714 P.2d 399 (1986). The State points out that in *Vitek*, where the Court held that due process entitled a prisoner to a hearing before transfer to a state mental hospital for a mandatory behavior modifica-

tion treatment, the court required only an "independent decisionmaker", not a judge. See *Vitek*, at 495. The State further points out that in *Youngberg* the Court, noting that judges are not necessarily more qualified than appropriate professionals, found that a "professional decisionmaker" adequately protects the due process rights of mentally disabled persons. *Youngberg*, at 323. Similarly, in *Large v. Superior Court*, *supra* at 239, the Arizona Supreme Court held that antipsychotic drugs could be administered to a prisoner against his will pursuant to a treatment plan formulated by a professional in compliance with statutory or administrative requirements. The State concludes that the SOC policy provides an independent professional decisionmaker and thus affords prisoners ample due process. We disagree.

The Court in *Vitek* was concerned with the "stigmatizing consequences" of a transfer to a mental health hospital for involuntary psychiatric treatment consisting of a behavior modification program. See *Vitek*, at 494. Here, we are concerned with the administration of mind altering drugs that have adverse, potentially permanent, side effects. We believe that the highly intrusive nature of antipsychotic drug treatment warrants greater protections than those necessary to protect the interests at issue in *Vitek*.⁶ In *Youngberg*, the issue was whether a severely retarded man had received proper treatment in a state facility. *Youngberg*, at 309. No allegation that a hearing was required before any particular treatment was before the court. *Youngberg*, at 322. Moreover, while the court in *Large* did not explicitly require a judicial hearing prior to treatment, the prisoner there had already received a full statutory judicial hearing during which a judge had ruled on the necessity of treatment prior to his transfer to the prison mental health facility where treatment took place. *Large*, at 231 n.2.

We conclude that a judicial hearing is required before the State may administer antipsychotic drugs to a prisoner against his will. As noted by the Court in *Vitek v. Jones*,

⁶ In a case similar to *Vitek*, we held on equal protection grounds that a prisoner was entitled to a judicial hearing before he could be transferred against his will from prison to a separately administered mental health facility, to be given psychiatric treatment that included antipsychotic drugs. See *Harmon v. McNutt*, 91 Wn.2d 126, 587 P.2d 537 (1978).

supra at 495, "[i]t is precisely '[t]he subtleties and nuances of psychiatric diagnoses' that justify the requirement of adversary hearings."

The State next argues that extending full due process hearing rights to prisoners amounts to judicially extending the involuntary commitment statutes to prisoners. The State concludes that the considerations behind the civil commitment statutes are inapplicable to the prison context where individuals are committed only after conviction of a crime, having received extensive due process protections, and then only for a fixed maximum period of time.

The State's argument is unpersuasive. In *Schuoler*, we held that the statutory protection afforded by the involuntary treatment act was inadequate to protect the independently existing constitutional right to refuse ECT. See *In re Schuoler*, 106 Wn.2d 500, 509, 723 P.2d 1103 (1986). Here, we extend our analysis in *Schuoler* to recognize a right to refuse antipsychotic drug treatment. We do so on constitutional rather than on statutory grounds. Moreover, we conclude that the constitutional liberty interest in refusing ECT and antipsychotic drug treatment survives criminal conviction and incarceration just as it survives civil involuntary commitment. See *Large v. Superior Court*, *supra* at 236.⁷

Finally, the due process protection given to a criminal defendant before sentencing and incarceration protects rights distinct from those at issue here. Harper has never been adjudged insane, nor was he incarcerated for his mental condition.⁸ As stated by the Court in *Vitek v. Jones*, *supra* at 493-94:

⁷ The SOC Involuntary Medication Policy defines "gravely disabled" and "presents a likelihood of serious harm to himself or others" identically to the statutory definitions used in RCW 71.05, the involuntary commitment statute.

The State's promulgation of the SOC policy articulating a standard for involuntary medication may have created a protected liberty interest in itself. See, e.g., *Roberts v. Spalding*, 783 F.2d 867, 870 (9th Cir. 1986) (liberty interest in state administrative regulation may be created where a regulation places substantive limits on the exercise of official discretion); *Vitek v. Jones*, *supra*, at 488-89 (once a state has granted prisoners liberty interests, due process protections are necessary to insure that the state-created right is not arbitrarily abrogated).

⁸ The State's assertion that prisoners are released after a fixed maximum time period raises the possibility that Harper's prison sentence could

A criminal conviction and sentence of imprisonment extinguish an individual's right to freedom from confinement for the term of his sentence, but they do not authorize the State to classify him as mentally ill and to subject him to involuntary psychiatric treatment without affording him additional due process protections.

We conclude that the due process requirements enunciated in *Schuoler*, apply here as well.

At the threshold, we hold that a judicial hearing must be held to determine whether the State can treat a prisoner with antipsychotic drugs against his will. A court may order imposition of antipsychotic drug treatment upon a nonconsenting prisoner when the State proves (1) a compelling state interest to administer antipsychotic drugs, and (2) the administration of the drugs is both necessary and effective for furthering that interest.⁹ *Schuoler*, at 508.

In *Schuoler*, we listed four nonexclusive criteria sufficiently compelling to override a patient's objection to medical treatment: (1) preservation of life; (2) protection of third parties' interests; (3) prevention of suicide; and (4) maintenance of the ethical integrity of the medical profession. *Schuoler*, at 508. If the court determines that there exists a compelling state interest in administering antipsychotic drugs against a prisoner's will, then the court must determine whether such treatment is both necessary and effective. See *Schuoler*, at 508-09. The court should consider medical prognosis with and without the treatment, as well as alternative treatments. *Schuoler*, at 509.

A court asked to order * * * [antipsychotic drug treatment] for a nonconsenting patient must therefore

end while the SOC policy dictates that his involuntary medication continue. Before the State could continue medicating him, it would have to follow civil commitment proceedings, if not the *Schuoler* requirements, should he refuse.

⁹ We decline to apply a reasonable relation analysis to the medication policy at issue here as urged by the State for the first time in its reply to the Brief of Amicus Curiae.

The uniquely intrusive nature of antipsychotic drug treatment is distinguishable from the First Amendment interests involved in the cases cited by the State. See *Turner v. Safley*, — U.S. —, 96 L. Ed. 2d 64, 107 S. Ct. 2254 (1987) (inmate mail); *O'Lone v. Estate of Shabazz*, — U.S. —, 96 L. Ed. 2d 282, 107 S. Ct. 2400 (1987) (religious practices). We decline to follow those cases in this context.

consider the patient's desires before entering an order. The court should consider previous and current statements of the patient, religious and moral values of the patient regarding medical treatment and * * * [antipsychotic drug treatment], and views of individuals that might influence the patient's decision. If the patient appears unable to understand fully the nature of the * * * hearing — as severely mentally ill patients often are — the court should make a "substituted judgment" for the patient that is analogous to the medical treatment decision for an incompetent person. See *In re Ingram*, [102 Wn.2d 827] * * * at 838-42 [689 P.2d 1363 (1984)].

Schuoler, at 507. Thus, the court must set forth findings on (1) the State's interest in the treatment; (2) the necessity and effectiveness of the treatment; and (3) the desires of the patient or a substituted judgment by the court. *Schuoler*, at 507-08.

The prisoner

must be present at this hearing and must be represented by counsel. Included in the requirement of a judicial hearing are the rights to present evidence, to cross-examine witnesses, to be proceeded against under the rules of evidence, to remain silent, and to view and copy all petitions and reports in the court file.

Schuoler, at 510. A prisoner must be given reasonable notice and time to prepare for the hearing. The State must justify the court's authorization of antipsychotic drug treatment against a prisoner's will by "clear, cogent, and convincing" evidence." See *Schuoler*, at 510. Finally,

"[i]f the court grants the order for involuntary medication, it may place such time limits and conditions on the administration of the medication as are appropriate under the circumstances of the case."

Schuoler, at 511 (quoting *People v. Medina*, 705 P.2d 961, 974 Colo. 1985)).

III

The State's final argument is that Harper's suit must be dismissed because he has proved no violation of a "clearly established" constitutional right so as to overcome the State's qualified immunity under 42 U.S.C. § 1983. See

Harlow v. Fitzgerald, 457 U.S. 800, 818, 73 L. Ed. 2d 396, 102 S. Ct. 2727 (1982).

Under 42 U.S.C. § 1983, state officials are immune unless the official

knew or reasonably should have known that the action he took within his sphere of official responsibility would violate the constitutional rights of the * * * [person] affected, or if he took the action with the malicious intention to cause a deprivation of constitutional rights or other injury * * *

Wood v. Stickland, 420 U.S. 308, 322, 43 L. Ed. 2d 214, 95 S. Ct. 992 (1975); *Hocker v. Woody*, 95 Wn.2d 822, 825, 631 P.2d 372 (1981). The official must have an objectively reasonable belief that his or her conduct was constitutional. *Hocker*, at 825; *Wood*, at 321. Official conduct is per se unreasonable if contrary to clearly established constitutional rights. *Hocker*, at 825; *Wood*, at 322.

Although we have concluded here that the State's actions violated Harper's constitutional rights, courts have uniformly refused to award damages when the constitutional right allegedly violated was not clearly established at the time of the conduct. *Hocker*, at 826. In these cases, a defendant is said to have acted reasonably absent a showing of malicious intent. *Hocker*, at 826.

At the time of the State's actions at issue in this case, the law regarding prisoners' rights to refuse antipsychotic drug treatment was not clearly established. Neither state nor federal caselaw directly addressed the issue presented here, and no statutory violation occurred. Moreover, the Secretary of Corrections and his staff promulgated the SOC involuntary medication policy in response to the *Harmon* and *Vitek* decisions, after consultation with the Attorney General. See Finding of fact 3, Clerk's Papers, at 8-9. While reliance on the advice of counsel is not an absolute defense, it is a factor to be considered on the issue of good faith. *Hocker*, at 827. The record indicates that the State acted reasonably in formulating the policy challenged here, and in following that policy. We conclude that there was no disregard of a clearly established constitutional right and that the State acted reasonably, not maliciously, and in good faith. See *Hocker*, at 827.

We note that notwithstanding the State's immunity un-

der § 1983, Harper also seeks injunctive and declaratory relief. The trial court also did not reach Harper's state law claims. Therefore, this case is reversed and remanded for proceedings consistent with this opinion.

WE CONCUR:

APPENDIX B
IN THE SUPERIOR COURT
OF THE STATE OF WASHINGTON
IN AND FOR SNOHOMISH COUNTY

No. 85-2-00394-1

FINDINGS OF FACTS
AND CONCLUSIONS OF LAW

WALTER HARPER,

Plaintiff,

v.

STATE OF WASHINGTON, et al.,

Defendants.

This matter came for trial on March 9th and 10th, 1987, before the undersigned judge of the above-entitled court. Plaintiff appeared by and through his attorney Brian Reed Phillips, defendants appeared by and through their attorneys Kenneth O. Eikenberry, Attorney General and Michael Madden, Assistant Attorney General. The parties stipulated that defendant's answers to plaintiff's interrogatories, and exhibits thereto, could be considered by the Court as substantive evidence and the Court has considered those documents. Further, the Court has considered those documents. Further, the Court heard the testimony of defendant Dr. John Petrich and Jerry Minaker, Mental Health Director for the Department of Corrections. Having heard and considered this evidence, and having heard the arguments of counsel, the Court gave its oral opinion on March 10, 1987, in favor of defendants.

NOW, THEREFORE, Pursuant to Rule 52 of the Civil Rules for Superior Court, the Court makes the following Findings of Fact and Conclusions of law:

FINDINGS OF FACT

1. Nature of Action.

Plaintiff brings this action for declaratory, injunctive and monetary relief against involuntary administration of

anti-psychotic medicines pursuant to a policy of the Washington State Special Offender Center, which allows administration of such medications following a finding by an administrative hearing committee that a prisoner is gravely disabled, or a danger to himself or others. Plaintiff contends that a judicial hearing whereat he would be afforded the assistance of counsel is necessary before such drugs may be involuntarily administered. Plaintiff contends that the involuntary medication policy of the Special Offender Center violates the due process and equal protection clauses of the state and federal constitutions and that the involuntary administration of anti-psychotic medicines to him constituted the torts of battery and outrage. Defendants contend that the administrative hearing process set forth in the Special Offender Center policy is constitutional and that their actions were privileged in the circumstances.

The Plaintiff did not attend trial in this cause. Plaintiff sought an order transporting him from the Washington State Penitentiary at Walla Walla to Everett so that he could attend trial, testify (as to the effects of the medication and the conduct of hearings whereat it was decided to involuntarily medicate him), and assist his counsel. The Court found, after weighing the risks, benefits and expense, that Plaintiff's presence was not necessary and did not issue an order requiring his transport.

2. Special Offender Center.

The Special Offender Center (SOC) is a one hundred and forty-four bed correctional institution administered by the Department of Corrections pursuant to RCW 72.65.010. Its function is to provide diagnosis and treatment of convicted felons sentenced to prison who have serious behavioral or mental disorders. SOC employs psychiatrists, psychologists, and therapists for this purpose and with the goal of allowing behaviorally or mentally disturbed inmates to attain a level of functioning such that they can be transferred to one of the other correctional institutions of the state to serve their sentence. Of the one hundred and forty-four inmates currently housed at SOC, approximately twenty-seven are being involuntarily medicated pursuant to the challenged policy.

3. SOC Policy.

Shortly after the decision of the United States Supreme Court in *Vitek v. Jones*, 455 U.S. 480 (1980), Department of Corrections officials began developing a policy for involuntary administration of anti-psychotic medications to SOC inmates. SOC policy 600.30 was ultimately adopted after review by the Secretary of Corrections and his staff in consultation with the Attorney General, and after consideration of the impact of *Harmon v. McNutt*, 91 Wn.2d 126 (1978) and *Vitek v. Jones*. As adopted and amended during the period relevant to this case, the challenged policy provides:

a. That a prisoner may be involuntarily medicated only where he suffers from a mental disorder and as a result of which is either gravely disabled or presents a likelihood of serious harm to himself or others. The policy defines these terms identically to the statutory definitions contained in RCW 71.05.

b. Medications must be ordered by, or in emergencies, approved by a psychiatrist. Where the patient/prisoner refuses medication, a special hearing committee is convened, consisting of a psychiatrist, psychologist, and the Associate Superintendent of SOC. None of the committee members may be currently involved in treatment or diagnosis of the patient. The Committee decides, based on majority vote, whether the patient is gravely disabled or dangerous, provided that if medication is to be approved the psychiatrist must vote with the majority.

c. The prisoner has certain procedural rights prior to the hearing, including; i. twenty-four hours notice, during which time he may not be medicated; ii. notice of the tentative diagnosis, factual basis for the diagnosis, and the basis on which medical treatment is necessary.

d. At the hearing, the prisoner has the right to be present and present evidence; the institution is required to present its evidence; the inmate may present his own witnesses and cross examine the staff witnesses. The prisoner is also entitled to a lay advisor who has not been involved with the case and who has an understanding of the psychiatric issues in the case.

e. Minutes of the hearing are kept and the prisoner has the right to appeal to the SOC Superintendent.

f. After the initial hearing, involuntary medication can continue only with periodic reviews. Under the policy in effect when plaintiff was initially involuntarily treated, medication could continue only for seven days, at which time the hearing committee would again review the case. If treatment was again approved, and continued for fourteen days or longer, then the treating psychiatrist was required to review the case every fourteen days and to prepare a report which would be forwarded to the Department of Corrections medical Director in Olympia for review. These fourteen day reviews continued so long as the patient was involuntarily medicated. Subsequently, SOC policy 600.30 was amended to allow initial treatment for fourteen days to be followed by a second hearing on the written record, by the same committee. If long term medication was then approved, bi-weekly reports by the psychiatrist to the Department of Corrections Medical Director were required, and if treatment continued for one hundred and eighty days, a new hearing to consider the need for further treatment was held.

4. Plaintiff.

Plaintiff was sentenced to prison in 1976 for robbery. He was not adjudged not guilty by reason of insanity. He was incarcerated pursuant to this conviction from 1976 to 1980, during which time he was held at the Washington State Penitentiary where, at various times, he was housed in the mental health unit and was treated voluntarily with anti-psychotic medications, by defendant Dr. John Petrich. On several occasions, pursuant to then existing policy, plaintiff was transferred to Eastern State Hospital for evaluation and treatment. Plaintiff was paroled in 1980 with the condition that he participate in psychiatric treatment. While on parole, plaintiff was committed to the psychiatric ward at Harborview Medical Center and was civilly committed to Western State Hospital. His parole was revoked in December of 1981, after he assaulted two nurses at Cabrini Hospital, Seattle.

5. Voluntary Treatment at SOC.

Upon returning to prison plaintiff was sent to SOC in January 1982, where he was again treated by defendant Dr. John Petrich. No judicial hearing was held prior to this transfer. The transfer was accomplished at the direction of

the Department of Corrections. Plaintiff voluntarily participated in treatment there, including administration of anti-psychotic medications from January to February 1982 and May to November, 1982, when he began refusing his medications. Plaintiff has been diagnosed by Dr. Petrich and other psychiatrists at SOC as suffering from manic depression, schizo-affective disorder, or schizophrenia. According to Dr. Petrich, the diagnosis has changed over time from the initial diagnosis of manic-depressive disorder to the current diagnosis of schizophrenia. Plaintiff's history includes incidents of assaultive behavior, which his doctors attribute to his mental disease and which they believe increased when he did not take his medications.

6. Involuntary Treatment

On November 23, 1982, at the request of defendant Dr. Petrich, a hearing committee was convened pursuant to SOC policy 600.30 consisting of defendant doctors Janiese Lieken and Phillip Giles and William Stark, Associate Superintendent of SOC. Plaintiff was present and assisted by a nurse practitioner from another institution. The hearing took place in accordance with policy and the committee found that, as a result of a mental disease or disorder, plaintiff was a danger to others. They then authorized his involuntary medication. Plaintiff appealed this finding to the institution superintendent, defendant Tom Rolffs, who upheld the committee's findings.

The decision to involuntary medicate the Plaintiff was reviewed on December 8, 1982 by a special hearing committee comprised of defendants Stark, Petrich, and Giles. Messieurs Stark and Giles had participated as members of the hearing committee on November 23, 1982. Defendant doctor Petrich had not participated as a member of the November 23, 1982 hearing committee because he was the treating physician. He was not the treating physician as of December 8, 1982.

a. The plaintiff remained on involuntary medication status from November 23, 1982, to approximately November 15, 1983, during which time he received the required review hearings and medical reviews under SOC policy 600.30.

b. Plaintiff was transferred from the SOC to the Wash-

ington State Reformatory on November 16, 1983. He did not take any medications following his transfer and, consequently, his condition deteriorated, he decompensated, and on December 22, 1983, he was returned to SOC.

c. On December 30, 1983, plaintiff appeared before a special hearing committee pursuant to SOC policy 600.30 to determine whether involuntary medication should be administered. Defendants Stark and Giles were members of the hearing committee. The hearing took place in accordance with the policy and the decision was made to continue to medicate plaintiff involuntarily.

d. Thereafter, and continuing until June 1986, when he was transferred to the Washington State Penitentiary, anti-psychotic medications were administered to plaintiff under SOC policy 600.30. At all times, plaintiff received the required medical reviews and hearings under the policy and was accorded his procedural rights thereunder.

7. **Conduct of Hearing.**

The conduct of the special hearings required under SOC policy 600.30 is set forth in the hearing minutes included in the record. In addition, testimony of Dr. Petrich indicates that prior to the hearing, the hearing committee members would consult with the staff outside the presence of the plaintiff for the purpose of ascertaining whether the requirements of the policy had been met and what the position of the staff would be at the hearing.

SOC staff members would summarize their position for the hearing committee by briefly presenting their reasons as to why the plaintiff was dangerous and why his condition was a product of a mental disorder. Mr. Harper would then be brought into the hearing which would take place in accordance with the policy. Mr. Harper would then be excused during the committee's deliberations, brought back to be informed of the decision, and the committee members would later dictate their decision and reasons.

The plaintiff, who was indigent, was not afforded counsel at any of the hearings nor does SOC policy allow for representation by counsel at such hearings.

During the course of the plaintiff's involuntary treatment at SOC he was regularly afforded hearings at which the

decisions to continue involuntary treatment were reviewed and approved. On December 30, 1983, a hearing was held before committee members and defendants Stark, Rowlett, and Giles. On January 5, 1984, a review was had by defendants Giles, Storrie-Lombardi, and Jerry Minaker (not a defendant). On October 31, 1984, a hearing was held before defendant Petrich and two non-defendants, G. Konzelman and D. Dunnington. A review hearing was had by the same persons on November 7, 1984. On May 1, 1985, a review hearing was held before defendant Petrich and two non-defendants. On January 30, 1986, a review hearing was held before three non-defendants.

At various times during the course of defendant's treatment, members of the hearing committees had been or were subsequently treating physicians. This is true of defendant doctors Loeken, Rowlett, Storrie-Lombardi, and Petrich. At no time was a treating physician a member of a hearing committee at the time said physician was prescribing medication.

8. **Plaintiff's Present Status**

In July 1986, plaintiff was transferred to the Washington State Penitentiary at Walla Walla where he is at present and has not been at SOC nor subject to the SOC involuntary medication policy since that time.

9. **Medications Administered and Side Effects**

During the time he has been treated by defendants, both voluntarily and involuntarily, plaintiff has received a variety of anti-psychotic drugs, including Trialafon; Haldol; Prolixin; Taractan; Loxitane; Mellaril; and Navane. These medications are believed to affect the chemical balance in the brain and are administered with the intent of assisting the patient to organize his or her thinking and to regain a rational state of mind. All of these medications have similar potential neurological side effects, which may be broadly classified as dystonia, akathisia and tardive dyskinesia. Dystonia is an involuntary spasm of the upper body, tongue, throat, or eyes. It is an acute, severe, intense and undesired reaction to anti-psychotic medications. It is easily treated with the side-effect medication Cogentin, and may be rapidly reversed within a few minutes. Akathisia is not so dramatic and is usually manifested by an uncontrollable fidget. It is reversible by

reduction of the dosage of anti-psychotic medication. Tardive dyskinesia is a hidden side effect of anti-psychotic medications, which may manifest itself years after treatment in the form of involuntary movements of the mouth, lips, and tongue.

10. Plaintiff's Side-Effects

Plaintiff complained of and may have exhibited symptoms of acute dystonic reaction and akathisia. He did not exhibit symptoms of tardive dyskinesia. Dr. Petrich did believe that plaintiff suffered dystonia and akathisia but was sometimes skeptical of plaintiff's complaints of side-effects and felt that they might be feigned.

11. Plaintiff's Mental Condition

At all times relevant to this action, plaintiff suffered from a mental disorder and as a result of that disorder constituted a likelihood of serious harm to others.

12. Plaintiff's Medical Treatment

At all times relevant to this action, the medical treatment provided to plaintiff by defendants, including the administration of anti-psychotic medications, was consistent with the degree of care, skill, and learning expected of a reasonably prudent psychiatrist in the State of Washington, acting in the same or similar circumstances.

13. Defendants' Compliance with SOC Policy

At all times relevant to this action, defendants substantially complied with the requirements of SOC policy 600.30 as amended.

Based on the foregoing Findings of Fact, the Court makes the following Conclusions of Law.

Conclusions of Law

1. Plaintiff has a liberty interest, protected by the due process clauses of the federal and state constitutions, in not being involuntarily subjected to treatment with anti-psychotic medications without due process.

2. Decisions of the Special Hearing Committee pursuant to SOC policy 600.30 are subject to judicial review by means of a personal restraint petition, or extraordinary writ in the superior court. The record compiled pursuant to SOC policy

600.30 is sufficient to allow judicial review of decisions made thereunder.

3. SOC policy 600.30 is consistent with the due process requirements of the federal constitution as established in *Vitek v. Jones*, 455 U.S. 480 (1980).

4. *Harmon v. McNutt*, 91 Wn.2d 126 (1978) is distinguishable from the instant case in that it deals with the question of transfer from a correctional institution to a separately administered mental health facility. SOC is not a separately administered mental health facility. Further, *Harmon* indicates that a separate judicial hearing is not required before involuntarily treating a mental health patient.

5. Accordingly, the question what is the appropriate medical treatment for plaintiff is more limited than the issues in a civil commitment proceeding to RCW 71.05, or a prison to mental health facility transfer under *Harmon v. McNutt*. SOC policy 600.30 provides adequate protection of the plaintiff's liberty interests and is in compliance with the due process and equal protection clauses of the state and federal constitutions.

6. Plaintiff's complaint should therefore be dismissed with prejudice and judgment entered in favor of defendants.

DONE IN OPEN COURT this 12th day of May, 1987.

DANIEL T. KERSHNER, JUDGE

Presented by:

BRIAN REED PHILLIPS
Attorney for Plaintiff

Approved as to form and notice
of Presentation waived:

KENNETH O. EIKENBERRY
Attorney General

MICHAEL MADDEN
Assistant Attorney General
Attorney for Defendants

APPENDIX C

DEBATE OVER PSYCHIATRIC CARE

COURT MUST OK DRUG TREATMENT IF PATIENT BALKS

by Jim Simon
Times staff reporter

On the fourth floor of the featureless concrete building that houses Highline Evaluation and Treatment Facility on First Hill, a frightened patient in his 30s is being held under nearly round-the-clock surveillance.

The man, diagnosed as a paranoid schizophrenic, sometimes hides under his bed or in a closet, urinates on himself and refuses to eat. Highline staff members believe powerful anti-psychotic drugs could ease his inner turmoil, but they can't give them to him.

Leo Perry, clinical director at Highline, calls the man one of the first "victims" of the Harper decision, a recent state Supreme Court ruling that prohibits mental-health institutions from giving patients anti-psychotic drugs against their will without a court order.

In the Highline man's case, a medication hearing before a King County Superior Court judge was scheduled for today, a week after he was admitted.

"It wasn't a matter of choice," Perry said. "The man is too psychotic to give us permission so we're frightened to give him medication. He's been reduced to being an animal while we wait for a court decision."

Perry and others charge that a well-intentioned court ruling is creating bad medicine.

Many hospital officials say anti-psychotic drugs could help many of these patients in a short period of time, but because of the court ruling, medication can't be administered for days and in some cases, up to two weeks.

Harborview Medical Center says about 40 percent of the patients involuntarily committed, and for whom anti-psychotic drugs have been recommended, have refused to take them since the decision.

The three King County facilities that handle involuntary commitment cases are Highline, Harborview and Northwest Evaluation and Treatment Center.

Officials from Harborview and other facilities contend that because attorneys need time to prepare, it can take a minimum of two days to get a hearing on whether a patient can be given medication or not. Some have had to wait for up to two weeks.

Those facilities also grumble that sending doctors to testify at hearings is both time-consuming and expensive. They claim that withholding drug treatment also will prolong the stay of many patients in institutions.

The ruling has forced Harborview and other Seattle facilities to use less effective medications, primarily tranquilizers, and to use leather restraints and seclusion rooms — sometimes for extended periods — far more frequently. Highline says its seclusion rooms, which once sat empty most days, have been in use nearly half the time since the Harper decision.

Northwest Evaluation and Treatment Center in Seattle says one patient who refused anti-psychotic drugs injured three staff members when he flew out of control.

Vancouver Memorial Hospital, which serves Clark, Klickitat and Skamania counties, has refused to accept involuntary commitment patients until liability issues are ironed out. Those in need of care are shipped by ambulance two hours away to overcrowded Western State Hospital in Steilacoom.

Some families of the mentally ill say the ruling is also causing them anguish. One Seattle man — whose son has a long history of mental illness and is now in the King County Jail, where he refuses medication — is angry.

"When he takes drugs, he's able to lead a productive, stable life," said the man of his son. "It's an injustice. He's not competent to make that decision (about not taking drugs). It's just another obstacle to his getting treatment."

But when the state Supreme Court in July unanimously upheld prison inmate Walter Harper's right to have a judicial hearing before being given medication, it was hailed as a significant civil-liberties victory for the mentally ill.

A month ago, the state attorney general's office said the

court's decision applied not just to prisons but to all mental-health institutions that care for patients involuntarily committed.

The court noted that anti-psychotic drugs can have potentially permanent side effects such as tardive dyskinesia, which causes uncontrollable twitching and loss of muscle control. It allowed facilities to continue giving tranquilizers such as Valium and Librium.

John Hertog, one of Harper's attorneys, said he believes the decision was inevitable because courts have ruled that mental patients have the right to refuse other mind-altering treatments such as shock treatment.

At least a dozen states, including California, New York and Massachusetts, now require judicial hearings before allowing the use of anti-psychotic drugs against a patient's will, Hertog said.

"What this really means is that mental patients have the right to make a decision about what will be done to their bodies," said Hertog. "This may sound cold, but to some extent mentally ill people, like those in other areas of life, have a right to make bad decisions."

Hertog and other backers of the ruling say mental-health providers are overreacting.

Studies of similar laws elsewhere show about 5 to 10 percent of mental patients refuse medication, said Hertog. In the majority of those cases, he said, courts sided with doctors who recommended medication.

Harborview, which at first threatened to stop accepting mental patients under the ruling, still hasn't sought court orders forcing patients to take anti-psychotic drugs.

But Dr. Seth Cohen, assistant director of inpatient psychiatric services at Harborview, believes the ruling is a step backward because it prevents patients from getting the best-known treatment.

On Harborview's eighth-floor ward, an emaciated young man is propped up on a gurney, a green feeding tube running into his nose, his arms and legs bound with cloth. As Cohen asks questions, the man mumbles incoherently and continues staring into space without a glimmer of recognition.

The patient has been detained like this for two weeks awaiting a hearing on whether doctors can administer shock

treatment. Cohen says he would normally have given the man, who has suffered some side effects from anti-psychotic drugs in the past, a low dosage of medication to stabilize his condition.

But because that would require another hearing — and possibly delay or jeopardize efforts to get shock treatment for the man — the patient will not get the drugs.

"My concern is having a judicial body dictate how medicine is practiced," Cohen said. "We're a treatment facility, but some of our patients aren't going to get any treatment."

State Sen. Phil Talmadge, D-Seattle, agrees. The result of allowing judges to decide who gets medication, he warns, will be "to bring back straitjackets and restraints as a form of treatment."

The Harper ruling is likely to prompt new patient-rights legislation during the 1989 state legislative session.

Talmadge, acting on behalf of Northwest and Highline treatment centers, said he is considering introducing a bill that would speed up the hearing process and set guidelines on giving mental patients anti-psychotic drugs in emergency situations.

But Dan Rader, who runs a federally funded advocacy program for patients at Western State, says once the furor dies down, he believes the Harper decision will have a positive effect on treatment. The courts will probably side with the doctor during most medication hearings, he predicts.

"Harper will have the salutary effect of forcing clinicians to look longer and harder at their decisions to use drugs," Rader added.

Dr. S. P. Thorward, Vancouver Memorial's psychiatric director, says he fears psychiatrists in private practice will stop treating involuntary-commitment patients if they must continually appear at court hearings.

OPPOSITION BRIEF

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NO. 88-599

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM 1988

STATE OF WASHINGTON, et al.,
Petitioners,
vs.
WALTER HARPER,
Respondent.

RESPONSE TO PETITION
FOR A WRIT OF CERTIORARI TO THE
SUPREME COURT OF WASHINGTON

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Respondent.

RESPONSE TO PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF WASHINGTON

Respondent, Walter Harper, by and through Brian Reed Phillips, respectfully prays for an order denying a writ of certiorari to review the judgment of the Supreme Court of the State of Washington.

OPINION OF THE SUPREME COURT OF THE STATE OF WASHINGTON

The Washington Supreme Court opinion, reversing the trial court and remanding for proceedings consistent with the opinion, is printed at 110 Wn.2d 873, ___ P.2d ___ (1988) (9-0 decision) (Copy attached as Appendix A).

**CONSTITUTIONAL PROVISIONS
INVOLVED**

(A) Amendments to the Federal Constitution.

First Amendment. Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the government for a redress of grievances.

Fourth Amendment. The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no warrants shall issue, but upon probable cause, supported by oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.

Fifth Amendment. No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment of indictment of a grand jury, except in cases arising in the land or naval forces, or in the militia, when in actual service in time of war or public danger; nor shall any person be subject for the same offense to be twice put in jeopardy of life or limb, nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life,

liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

Ninth Amendment. The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.

Fourteenth Amendment. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

(B) Washington State Constitution, Article 1, section 7. No person shall be disturbed in his private affairs, or his home invaded, without authority of law.

STATEMENT OF THE CASE

Respondent accepts the Statement of the Case as provided by Petitioners in their Petition for a Writ of Certiorari to the Supreme Court of the State of Washington.

ARGUMENT

1. The Washington State Supreme Court correctly held that a prisoner's fundamental liberty interest in refusing treatment with antipsychotic drugs requires a judicial hearing prior to the involuntary administration of such drugs. Justice Brachtenbach in his opinion clearly and cogently set forth the grounds for the lower court's decision. Respondent respectfully refers this Court to that decision and will not set forth argument herein. See appendix A.

2. Assuming this Court were to reverse the decision of the Washington State Supreme Court, it is an almost certainty that that Court would nonetheless reach the same conclusion, this time resting the conclusion on independent state grounds. The lower court's decision was unanimous, 9-0.

In Harper, the Court did not specifically mention independent state grounds as a basis for its decision. However, in reaching its result, the Court repeatedly cited to In re Schuoler, 106 Wn.2d 500, 723 P.2d 1103 (1986), In re Ingram, 102 Wn.2d 827, 689 P.2d 1363 (1984) and In re Coyler, 99 Wn.2d 114, 660 P.2d 738 (1983). In Coyler, the Court specifically cited to a provision of the Washington State Constitution.

[W]e now hold that an adult who is incurably and terminally ill has a [federal] constitutional right of privacy that encompasses the right to refuse treatment that serves only to prolong the dying process, given the absence of countervailing state interest. Support for this holding is also found in our state constitution. Const. art. 1, subsection 7.

In re Coyler, 99 Wn.2d at 121 (emphasis added). Article 1, section 7 of the Washington State constitution provides that "[n]o person shall be disturbed in his private affairs, or his home invaded, without authority of law." Recourse to this and other provisions of the state constitution in order to provide greater protection for individual rights than does the United States Constitution has been had since at least 1975. E.g. State v. Gunwall, 106 Wn.2d 54, 59, 720 P.2d 808 (1986) (Art. 1, sec. 7) State v. Jackson, 102 Wn.2d 432, 439, 688 P.2d 136 (1984) (Art. 1, sec. 7); State v. White, 97 Wn.2d 92, 108, 640 P.2d 1061 (1982) (Art. 1, sec. 7); Alderwood Assocs. v. Washington Env'tl. Coun., 96 Wn.2d 230, 238, 635 P.2d 108 (1981) (free speech); Darrin v. Gould, 85 Wn.2d 859, 868, 540 P.2d 882 (1975) (equal protection); See Utter (Justice), Freedom and Diversity in a Federal System: Perspectives on State Constitutions and the

Washington Declaration of Rights, 7 U. Puget Sound L.
Rev. 491 (1984).

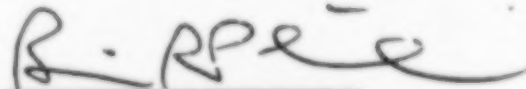
Additionally, in both the Coyler and Ingram
decisions, the Court made specific reference to the
"common law right to be free from bodily invasion . . .
." " In re Coyler, 99 Wn.2d at 121; In re Ingram, 102
Wn.2d at 836.

Given the unanimous opinion of the Washington State
Supreme Court and the frequent recourse of that court
to state constitutional principles, it is a near
certainty that, if reversed by this court, the state
court would find independent state constitutional
grounds to reach the same result. In this sense, the
petition is needless prolongation of this litigation.

CONCLUSION

For the reasons set forth above, the Petition
should be denied.

Respectfully submitted this 20th day of January,
1989.



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CONCLUSION

The trial court's failure to instruct on the use of character evidence was prejudicial error. I would reverse the trial court and the Court of Appeals and remand for a new trial.

GOODLOR, J., concurs with DORE, J.

[No. 54045-4. En Banc. July 7, 1988.]

WALTER HARPER, *Appellant*, v. THE STATE OF
WASHINGTON, *Respondent*.

- [1] Prisons — Mental Health — Prison Inmate — Involuntary Administration of Antipsychotic Drugs — Liberty Interest. A prisoner has a fundamental liberty interest in refusing treatment with antipsychotic drugs.
- [2] Prisons — Mental Health — Prison Inmate — Involuntary Administration of Antipsychotic Drugs — Judicial Hearing — Burden and Degree of Proof. When the State desires to administer antipsychotic drugs to a prisoner against his will, a judicial hearing must be held at which the State has the burden of establishing by clear, cogent, and convincing evidence that the administration of the drugs is both necessary and effective to further a compelling state interest. The prisoner is entitled to due process protections, including reasonable notice and time to prepare for the hearing, the right to attend the hearing and be represented by an attorney, and other constitutional safeguards applicable to criminal trials.
- [3] Civil Rights — Deprivation — Immunity — State — New Constitutional Right. The State is immune from liability under 42 U.S.C. § 1983 for its violation in good faith of a person's constitutional right that was not clearly established at the time of the violation.

Nature of Action: A prisoner who had been injected against his will with antipsychotic drugs sought injunctive, declarative, and monetary relief.

Superior Court: The Superior Court for Snohomish County, No. 85-2-00394-1, Daniel T. Kershner, J., entered a judgment in favor of the State on May 21, 1987.

Supreme Court: Holding that the prisoner was entitled to a judicial hearing before the administration of the drugs but that the State was immune from damages under 42 U.S.C. § 1983 for violating the prisoner's civil rights, the court reverses the judgment and remands the case for further proceedings.

Brian Reed Phillips, for appellant.

Kenneth O. Eikenberry, Attorney General, and Glenn L. Harvey, Assistant, for respondent.

John H. Hertug, Jr., and Neil R. Soles on behalf of the American Civil Liberties Union; James F. Pultz and Robert A. Stafler, Jr., on behalf of Evergreen Legal Services and Institutional Legal Services; William Salen and George Veonakis on behalf of Seattle-King County Public Defender Association, amici curiae for appellant.

BRACHTENBAUM, J.—Is a prisoner entitled to a judicial hearing before antipsychotic drugs can be administered against his will? The trial court answered no. We accepted direct review and reverse.

The facts are undisputed. Convicted of robbery, appellant Harper was sentenced in 1976 to the Washington State Penitentiary in Walla Walla. Between 1976 and 1980, Harper was housed primarily in the mental health unit there, where he voluntarily underwent antipsychotic drug therapy. Harper was transferred periodically to Eastern State Hospital for evaluation and treatment.

Harper was paroled in 1980 on condition that he participate in psychiatric treatment. He spent some of his parole time in the psychiatric ward at Harborview Medical Center in Seattle, and part at Western State Hospital, pursuant to a civil commitment order. In December 1981, Harper's

parole was revoked after he assaulted two nurses at Saint Cabrini Hospital in Seattle.

Following his return to prison, Harper was sent to the Special Offenders Center (SOC) at Monroe in January 1982. The SOC is a 144-bed correctional institution administered by the Department of Corrections. The SOC was established to provide diagnosis and treatment of convicted felons having serious behavioral or mental disorders. Approximately 37 inmates at the SOC receive involuntary medication.

While at the SOC, Harper voluntarily submitted to treatment, including administration of antipsychotic medications. In November 1982, Harper refused to continue taking the prescribed antipsychotic drugs. At Harper's treating physician's request, a hearing committee was convened to determine whether medication should be administered to Harper against his will. Harper does not dispute that the hearing took place in accord with SOC policy. The committee found that, as a result of mental disease or disorder, Harper was a danger to others. The committee authorized Harper's involuntary medication. Harper appealed the decision to the Monroe reformatory superintendent, who upheld the committee's decision.

Between November 1982 and June 1985, Harper was involuntarily medicated with a variety of antipsychotic drugs. During this period, Harper's treatment was reviewed by the committee approximately every 2 weeks. Each time, the committee decided to continue the medications, although the dosages or drugs were sometimes changed.

In February 1985, Harper filed this action for injunctive and monetary relief against the State,¹ for its administration of antipsychotic medications to him pursuant to SOC's involuntary medication policy. Harper was not present when the case was heard in superior court. Following trial,

¹Harper brought his claim pursuant to the Civil Rights Act of 1960, 42 U.S.C. § 1983. At trial, he alleged constitutional violations along with tort claims for assault, battery and outrage. See Complaint, at 6-7, Clerk's Papers, at 122-23.

the court dismissed Harper's complaint. Harper appealed directly to this court.

Harper does not dispute that the State followed the SOC involuntary medication policy. Instead, he contends that the policy fails to provide adequate due process protection because it allows the State to decide to administer antipsychotic medication against his will without a judicial hearing.¹

[1] Initially, we agree with the trial court's conclusion that Harper had a protected liberty interest in refusing antipsychotic drug treatment.² See conclusion of law I, Clerk's Papers, at 18. We have recognized that competent adults have a right to determine what shall be done to their bodies. *In re Schuoler*, 106 Wn.2d 500, 506, 723 P.2d 1103 (1986); *In re Ingram*, 102 Wn.2d 827, 836, 689 P.2d 1363 (1984); *In re Colyer*, 99 Wn.2d 114, 119, 660 P.2d 738 (1983). We also have specifically recognized a right to refuse electroconvulsive therapy. *In re Schuoler*, *supra*.

In *Schuoler*, the plaintiff was involuntarily committed because of severe mental problems. At her commitment hearing, her treating psychiatrist asked the court to authorize electroconvulsive therapy (ECT), which the plaintiff had refused to undergo. Following a separate hearing on the issue, the trial court authorized ECT. This court

¹Because we decide this case on due process grounds, we do not address Harper's equal protection or free speech claims.

²Antipsychotic drugs are also referred to as psychotropic drugs, neuroleptics, and major tranquilizers. See Kemna, *Current Status of Institutionalized Mental Health Patients' Right To Refuse Psychotropic Drugs*, 6 J. Legal Med. 107, 109 (1985); *The Pharmacological Basis of Therapeutics* 152, 172-74 (A. Gilman, L. Goodman, & Gilman ed. 6th ed. 1980) (Goodman & Gilman's). This category of drugs commonly includes phenothiazines (e.g., Thorazine, Meprobamate, Prolixin), thioxanthenes (e.g., Nevanol) and other heterocyclic compounds (e.g., Haloperidol). Goodman & Gilman's, at 391-408. The drugs administered to Harper included Trifluoperazine, Haloperidol, Prolixin, Taractan, Lorazepam, Mellaril, and Nevanol. See finding of fact 9, Clerk's Papers, at 16.

Our holding here applies specifically to this category of drugs.

reversed, holding that "a person involuntarily committed due to a mental disorder retains a fundamental liberty interest in refusing ECT." *Schuoler*, at 587. We noted that the right to refuse ECT was especially important because ECT is a highly intrusive medical procedure with well documented adverse side effects such as memory loss and impairment of learning ability. See *Schuoler*, at 506.

Like ECT, antipsychotic drug therapy is a highly intrusive form of medical treatment. See *Guardianship of Roe*, 383 Mass. 415, 435-37, 421 N.E.2d 40 (1981). Antipsychotic drugs are by intention mind altering; they are meant to act upon the thought processes. *Riese v. St. Mary's Hosp. & Med. Ctr.*, ___ Cal. App. 3d ___, 243 Cal. Rptr. 241 (1987); *Guardianship of Roe*, *supra*.

The benefits of antipsychotic drug treatment to acutely ill patients are well documented. See *The Pharmacological Basis of Therapeutics* 152, 172-74 (A. Gilman, L. Goodman, & Gilman 6th ed. 1980) (Goodman & Gilman's). Also documented, however, are the adverse side effects of antipsychotic drug treatment. Less serious, reversible side effects include dystonia, a severe involuntary spasm of the upper body, throat, tongue or eyes; akathisia, the inability to remain still, restlessness and agitation; and pseudo-Parkinsonism, manifested by a mask-like face, drooling, muscle rigidity, stiffness, tremors and a shuffling gait.³ See finding of fact 9, Clerk's Papers, at 11; Kemna, *Current Status of Institutionalized Mental Health Patients' Right To Refuse Psychotropic Drugs*, 6 J. Legal Med. 107, 111-13 (1985); Goodman & Gilman's, at 164-72. Although common, these effects can be controlled by administration of other drugs, adjustment of the dosage, or termination of the therapy. Kemna, at 112; Goodman & Gilman's, at 164-72. Severe and potentially permanent is tardive dyskinesia, an

³The record shows that Harper exhibited symptoms of dystonia and akathisia and was treated with the side effect medication, Cogentin. He did not show signs of tardive dyskinesia. See finding of fact 10, Clerk's Papers, at 12.

irreversible neurological disorder characterized by involuntary, uncontrollable movements of the tongue, mouth or jaw. Fingers, arms and legs may also be affected. Tardive dyskinesia can be masked by the drug causing the condition, and can manifest itself years after treatment has occurred. See finding of fact 9, Clerk's Papers, at 11; Kemna, *supra* at 113.

We find that antipsychotic drug treatment is no less intrusive than ECT. Therefore, we recognize a fundamental liberty interest in refusing antipsychotic drug treatment as well. Other courts have reached similar conclusions. See, e.g., *Riese v. St. Mary's Hosp. & Med. Ctr.*, *supra*; *People v. Medina*, 706 P.2d 961, 967 (Colo. 1985); *Rogers v. Commissioner of Dep't of Mental Health*, 390 Mass. 489, 458 N.E.2d 308 (1983); *Guardianship of Roe*, *supra* at 436-37 ("few legitimate medical procedures . . . are more intrusive than the forcible injection of antipsychotic medication. . . . Because of both the profound effect that these drugs have on the thought processes . . . and the well established likelihood of severe and irreversible adverse side effects . . . we treat these drugs in the same manner we would treat psychosurgery or electroconvulsive therapy").

II

The State argues that Harper's liberty interest in refusing treatment was adequately protected by the existing SOC involuntary medication policy. The trial court agreed. See conclusion of law 3, Clerk's Papers, at 66.

The SOC involuntary medication policy provides for a hearing prior to the administration of antipsychotic drugs. See generally finding of fact 3, Clerk's Papers, at 8-11. Hearings are held before a committee composed of a psychiatrist, a psychologist, and the SOC associate superintendent. Finding of fact 3(b), Clerk's Papers, at 9. A prisoner can be medicated against his will if a majority⁵ of the committee finds that he suffers from a mental disorder

⁵ If medication is approved, the psychiatrist must vote with the majority. Finding of fact 3(b), Clerk's Papers, at 9.

gravely disabling him or causing him to present a likelihood of serious harm to himself or others. Finding of fact 3(a), Clerk's Papers, at 9.

The policy grants the following procedural protections: 24-hour notice of the SOC's intent to convene an involuntary medication hearing; the right to be present and to present evidence, including witnesses; the right to cross-examine the staff witnesses; the assistance of a lay adviser; the right to appeal the decision to the SOC superintendent; and the right to periodic reviews subsequent to the initial hearing. Finding of fact 3, Clerk's Papers, at 8-11.

The policy does not allow representation by counsel. Finding of fact 7, Clerk's Papers, at 14. The rules of evidence do not apply. The policy does not provide for review of the committee's decision, except by personal restraint petition or extraordinary writ to the superior court. See conclusion of law 2, Clerk's Papers, at 18. Also, although a prisoner's treating physician who has recommended the involuntary medication cannot sit on the initial committee, he can sit on subsequent panels reviewing continued treatment if he is at that time no longer the treating physician, creating a conflict of interest the policy apparently meant to avoid. See findings of fact 6, 7, Clerk's Papers, at 13-15.

Prior to an involuntary medication hearing, committee members consult with the SOC staff outside the presence of the prisoner to determine whether policy requirements have been met and what the staff's position will be at the hearing. Finding of fact 7, Clerk's Papers, at 14. Staff members then summarize their positions for the hearing committee and briefly present their reasons as to why the prisoner is dangerous and why his condition is a product of a mental disorder. Finding of fact 7, Clerk's Papers, at 14. The prisoner is brought into the hearing, which then proceeds in accordance with policy. Finding of fact 7, Clerk's Papers, at 14. The prisoner is excused during the committee's deliberations, after which the prisoner is brought back in and informed of the committee's decision. Finding of fact 7, Clerk's Papers, at 14. The committee later dictates its

final decision and findings. Finding of fact 7, Clerk's Papers, at 14-15.

The State contends that no judicial hearing is required, urging that a decision based on professional judgment adequately protects prisoners' rights to refuse antipsychotic drug treatment.

The State relies on *Vitek v. Jones*, 445 U.S. 480, 495, 63 L. Ed. 2d 552, 100 S. Ct. 1254 (1980); *Youngberg v. Romeo*, 457 U.S. 307, 73 L. Ed. 2d 28, 102 S. Ct. 2452 (1982); and *Large v. Superior Court*, 148 Ariz. 229, 714 P.2d 379 (1986). The State points out that in *Vitek*, where the Court held that due process entitled a prisoner to a hearing before transfer to a state mental hospital for a mandatory behavior modification treatment, the Court required only an "independent decisionmaker", not a judge. See *Vitek*, at 495. The State further points out that in *Youngberg* the Court, noting that judges are not necessarily more qualified than appropriate professionals, found that a "professional decisionmaker" adequately protects the due process rights of mentally disabled persons. *Youngberg*, at 323. Similarly, in *Large v. Superior Court*, *supra* at 239, the Arizona Supreme Court held that antipsychotic drugs could be administered to a prisoner against his will pursuant to a treatment plan formulated by a professional in compliance with statutory or administrative requirements. The State concludes that the SOC policy provides an independent professional decisionmaker and thus affords prisoners ample due process. We disagree.

The Court in *Vitek* was concerned with the "stigmatizing consequences" of a transfer to a mental health hospital for involuntary psychiatric treatment consisting of a behavior modification program. See *Vitek*, at 494. Here, we are concerned with the administration of mind altering drugs that have adverse, potentially permanent, side effects. We believe that the highly intrusive nature of antipsychotic drug treatment warrants greater protections than those

necessary to protect the interests at issue in *Vitek*.⁶ In *Youngberg*, the issue was whether a severely retarded man had received proper treatment in a state facility. *Youngberg*, at 309. No allegation that a hearing was required before any particular treatment was before the Court. *Youngberg*, at 322. Moreover, while the court in *Large* did not explicitly require a judicial hearing prior to treatment, the prisoner there had already received a full statutory judicial hearing during which a judge had ruled on the necessity of treatment prior to his transfer to the prison mental health facility where treatment took place. *Large*, at 234 n.2.

[2] We conclude that a judicial hearing is required before the State may administer antipsychotic drugs to a prisoner against his will. As noted by the Court in *Vitek v. Jones*, *supra* at 495, "[i]t is precisely '[t]he subtleties and nuances of psychiatric diagnoses' that justify the requirement of adversary hearings."

The State next argues that extending full due process hearing rights to prisoners amounts to judicially extending the involuntary commitment statutes to prisoners. The State concludes that the considerations behind the civil commitment statutes are inapplicable to the prison context where individuals are committed only after conviction of a crime, having received extensive due process protections, and then only for a fixed maximum period of time.

The State's argument is unpersuasive. In *Schuler*, we held that the statutory protection afforded by the involuntary treatment act was inadequate to protect the independently existing constitutional right to refuse ECT. See *In re Schuler*, 106 Wn.2d 500, 509, 723 P.2d 1103 (1986). Here, we extend our analysis in *Schuler* to recognize a right to

⁶In a case similar to *Vitek*, we held on equal protection grounds that a prisoner was entitled to a judicial hearing before he could be transferred against his will from prison to a separately administered mental health facility, to be given psychiatric treatment that included antipsychotic drugs. See *Horman v. McNutt*, 82 Wn.2d 138, 507 P.2d 537 (1978).

refuse antipsychotic drug treatment. We do so on constitutional rather than on statutory grounds. Moreover, we conclude that the constitutional liberty interest in refusing ECT and antipsychotic drug treatment survives criminal conviction and incarceration just as it survives civil involuntary commitment. See *Large v. Superior Court*, *supra* at 236.⁷

Finally, the due process protection given to a criminal defendant before sentencing and incarceration protects rights distinct from those at issue here. Harper has never been adjudged insane, nor was he incarcerated for his mental condition.⁸ As stated by the Court in *Vitek v. Jones*, *supra* at 493-94:

A criminal conviction and sentence of imprisonment extinguish an individual's right to freedom from confinement for the term of his sentence, but they do not authorize the State to classify him as mentally ill and to subject him to involuntary psychiatric treatment without affording him additional due process protections.

We conclude that the due process requirements enunciated in *Schuoler* apply here as well.

At the threshold, we hold that a judicial hearing must be held to determine whether the State can treat a prisoner with antipsychotic drugs against his will. A court may order

⁷The SOC Involuntary Medication Policy defines "gravely disabled" and "presents a likelihood of serious harm to himself or others" identically to the statutory definitions used in RCW 71.06, the involuntary commitment statute.

The State's promulgation of the SOC policy articulating a standard for involuntary medication may have created a protected liberty interest in itself. See, e.g., *Roberts v. Spalding*, 783 P.2d 867, 870 (9th Cir. 1990) (liberty interest in state administrative regulation may be created where a regulation places substantive limits on the exercise of official discretion); *Vitek v. Jones*, *supra* at 488-89 (once a state has granted prisoners liberty interests, due process protections are necessary to insure that the state-created right is not arbitrarily abrogated).

⁸The State's assertion that prisoners are released after a fixed maximum time period raises the possibility that Harper's prison sentence could end while the SOC policy dictates that his involuntary medication continue. Before the State could continue medicating him, it would have to follow civil commitment proceedings, if not the *Schuoler* requirements, should he refuse.

imposition of antipsychotic drug treatment upon a nonconsenting prisoner when the State proves (1) a compelling state interest to administer antipsychotic drugs, and (2) the administration of the drugs is both necessary and effective for furthering that interest.⁹ *Schuoler*, at 508.

In *Schuoler*, we listed four nonexclusive criteria sufficiently compelling to override a patient's objection to medical treatment: (1) preservation of life; (2) protection of third parties' interests; (3) prevention of suicide; and (4) maintenance of the ethical integrity of the medical profession. *Schuoler*, at 508. If the court determines that there exists a compelling state interest in administering antipsychotic drugs against a prisoner's will, then the court must determine whether such treatment is both necessary and effective. See *Schuoler*, at 508-09. The court should consider medical prognosis with and without the treatment, as well as alternative treatments. *Schuoler*, at 509.

A court asked to order [antipsychotic drug treatment] for a nonconsenting patient must therefore consider the patient's desires before entering an order. The court should consider previous and current statements of the patient, religious and moral values of the patient regarding medical treatment and [antipsychotic drug treatment], and views of individuals that might influence the patient's decision. If the patient appears unable to understand fully the nature of the . . . hearing—as severely mentally ill patients often are—the court should make a "substituted judgment" for the patient that is analogous to the medical treatment decision for an incompetent person. See *In re Ingram*, [102 Wn.2d 827] at 838-42 [689 P.2d 1363 (1984)].

⁹We decline to apply a reasonable relation analysis to the medication policy at issue here as urged by the State for the first time in its reply to the Brief of Amicus Curiae.

The uniquely intrusive nature of antipsychotic drug treatment is distinguishable from the First Amendment interests involved in the cases cited by the State. See *Turner v. Bafley*, — U.S. —, 96 L. Ed. 2d 64, 107 S. Ct. 2254 (1987) (inmate mail); *Olson v. Estate of Shabazz*, — U.S. —, 96 L. Ed. 2d 282, 107 S. Ct. 2408 (1987) (religious practices). We decline to follow those cases in this context.

Schuler, at 507. Thus, the court must set forth findings on (1) the State's interest in the treatment; (2) the necessity and effectiveness of the treatment; and (3) the desires of the patient or a substituted judgment by the court. *Schuler*, at 507-08.

The prisoner

must be present at this hearing and must be represented by counsel. Included in the requirement of a judicial hearing are the rights to present evidence, to cross-examine witnesses, to be proceeded against under the rules of evidence, to remain silent, and to view and copy all petitions and reports in the court file.

Schuler, at 510. A prisoner must be given reasonable notice and time to prepare for the hearing. The State must justify the court's authorization of antipsychotic drug treatment against a prisoner's will by "clear, cogent, and convincing" evidence." See *Schuler*, at 510. Finally,

"[i]f the court grants the order for involuntary medication, it may place such time limits and conditions on the administration of the medication as are appropriate under the circumstances of the case."

Schuler, at 511 (quoting *People v. Medina*, 705 P.2d 961, 974 (Colo. 1985)).

III

The State's final argument is that Harper's suit must be dismissed because he has proved no violation of a "clearly established" constitutional right so as to overcome the State's qualified immunity under 42 U.S.C. § 1983. See *Harlow v. Fitzgerald*, 457 U.S. 800, 818, 73 L. Ed. 2d 396, 102 S. Ct. 2727 (1982).

[3] Under 42 U.S.C. § 1983, state officials are immune unless the official

knew or reasonably should have known that the action he took within his sphere of official responsibility would violate the constitutional rights of the [person] affected, or if he took the action with the malicious intention to cause a deprivation of constitutional rights or other injury . . .

Wood v. Strickland, 420 U.S. 308, 322, 43 L. Ed. 2d 214, 95 S. Ct. 992 (1975); *Hocker v. Woody*, 95 Wn.2d 822, 825, 631 P.2d 372 (1981). The official must have an objectively reasonable belief that his or her conduct was constitutional. *Hocker*, at 825; *Wood*, at 321. Official conduct is per se unreasonable if contrary to clearly established constitutional rights. *Hocker*, at 825; *Wood*, at 322.

Although we have concluded here that the State's actions violated Harper's constitutional rights, courts have uniformly refused to award damages when the constitutional right allegedly violated was not clearly established at the time of the conduct. *Hocker*, at 826. In these cases, a defendant is said to have acted reasonably absent a showing of malicious intent. *Hocker*, at 826.

At the time of the State's actions at issue in this case, the law regarding prisoner's rights to refuse antipsychotic drug treatment was not clearly established. Neither state nor federal case law directly addressed the issue presented here, and no statutory violation occurred. Moreover, the Secretary of Corrections and his staff promulgated the SOC involuntary medication policy in response to the *Harmon v. McNutt*, 91 Wn.2d 126, 587 P.2d 537 (1978) and *Vitek* decisions, after consultation with the Attorney General. See finding of fact 3, Clerk's Papers, at 8-9. While reliance on the advice of counsel is not an absolute defense, it is a factor to be considered on the issue of good faith. *Hocker*, at 827. The record indicates that the State acted reasonably in formulating the policy challenged here, and in following that policy. We conclude that there was no disregard of a clearly established constitutional right and that the State acted reasonably, not maliciously, and in good faith. See *Hocker*, at 827.

We note that notwithstanding the State's immunity under § 1983, Harper also seeks injunctive and declaratory relief. The trial court also did not reach Harper's state law

claims. Therefore, this case is reversed and remanded for proceedings consistent with this opinion.

PEARSON, C.J., and UTTER, DOLLIVER, DORE, ANDERSEN, CALLOW, GOODLOR, and DURHAM, JJ., concur.

[No. 54300-3. En Banc. July 7, 1988.]

THE STATE OF WASHINGTON, Respondent, v. S.P.,
Petitioner.

- [1] Statutes — Construction — Acts Relating to Same Subject. Related statutory provisions should be interpreted in relation to each other with all provisions being harmonized and given effect.
- [2] Juveniles — Juvenile Justice — Disposition — Right of Confrontation — Predisposition Report. Under RCW 13.40.150(1), a juvenile offender has a right to confront a "reasonably available" author of a predisposition report that is used, pursuant to RCW 13.40.150(3)(c), at the juvenile's disposition hearing if it is relevant and material in determining his disposition.

AMMONSON, J., concurs in the result only; DUNHAM, J., did not participate in the disposition of this case.

Nature of Action: Prosecution of a juvenile for indecent liberties.

Superior Court: The Superior Court for Skagit County, No. 85-8-00323-8, Hugh R. Ridgway, J. Pro Tem., on April 22, 1986, entered an adjudication of guilty and a disposition exceeding the standard range.

Court of Appeals: The court affirmed the judgment at 49 Wn. App. 45, holding that the admission of hearsay at the disposition hearing did not violate the defendant's right of confrontation.

Supreme Court: Holding that the defendant had a statutory right to confront the author of a report considered at the disposition hearing, the court reverses the decision of the Court of Appeals and the judgment and remands the case for a new disposition hearing.

Julie A. Kesler of Washington Appellate Defender Association, for petitioner.

Michael E. Richert, Prosecuting Attorney, and Daniel B. Pope, Deputy, for respondent.

GOODLOR, J.—Petitioner S.P., a juvenile, seeks review of a Court of Appeals decision that affirmed his sentence exceeding the standard range. *State v. S.P.*, 49 Wn. App. 45, 746 P.2d 813, review granted, 109 Wn.2d 1007 (1987). S.P. asserts that he was denied the right to confront witnesses against him at his disposition hearing. We reverse the Court of Appeals and remand to the juvenile court.

S.P. was convicted of two counts of indecent liberties; the first incident occurred in August 1985 and the second incident occurred in September 1985. The standard range for S.P.'s offenses was 42 to 56 weeks. However, the State sought a finding of manifest injustice. A "manifest injustice" is a "disposition that would either impose an excessive penalty on the juvenile or would impose a serious, and clear danger to society". RCW 13.40.020(12). A finding of manifest injustice must be established before the standard range can be exceeded in setting a juvenile's sentence. RCW 13.40.160(1). S.P. conceded that a finding of manifest injustice should be made but disagreed as to how far the standard range should be exceeded.

At S.P.'s disposition hearing, the juvenile court heard the oral testimony of probation officer James Donovan, social worker Nancy Larson, and Department of Juvenile Rehabilitation employee Dan Donnelly. The juvenile court admitted into evidence Donovan's manifest injustice hearing report. The juvenile court also considered Larson's mental health evaluation, psychologist Dr. Bruce Olson's

REPLY BRIEF

Supreme Court, U.S.

FILED

FEB 2 1989

JOSEPH F. SPANIOL, JR.
CLERK

No. 88-599

IN THE
SUPREME COURT
OF THE
UNITED STATES

OCTOBER TERM, 1988

STATE OF WASHINGTON, et al.,

Petitioners,

v.

WALTER HARPER,

Respondent.

PETITIONERS' RESPONSE TO BRIEF IN
OPPOSITION TO PETITION FOR WRIT OF
CERTIORARI

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WASHINGTON

I. ARGUMENT

Respondent Harper's argument that the petition should be denied because the Washington Supreme Court will likely reach the same conclusion solely on state grounds ignores the fact that the due process issue (judicial intervention v. professional judgment) in this § 1983 action is exclusively a question of federal constitutional law.

Not only is such an argument purely speculative, it ignores the appropriate analysis of this § 1983 case. The first step of the analysis is whether the Respondent possesses a protected liberty interest in refusing antipsychotic medication. Even assuming that the Washington Supreme Court would find such a liberty interest solely in state law, the next step of the analysis requires an examination of the proce-

dural protections appropriate under the Due Process Clause of the Fourteenth Amendment.

This is clear from the following discussion from this Court's opinion in *Vitek v. Jones*, 445 U.S. 480 (1980):

* * * [I]f the State grants a prisoner a right or expectation that adverse action will not be taken against him except on the occurrence of specified behavior, "[then] * * * the minimum requirements of procedural due process appropriate for the circumstances must be observed." *Wolff v. McDonnell*, 418 U.S. at 558, 94 S.Ct., at 2976. *These minimum requirements [are] a matter of federal law* * * *."

445 U.S. at 490-1 (emphasis added).

As to the appropriate federal due process analysis, the most recent examination of the issue rejected judicial intervention in favor of following this Court's teaching that the exercise of "professional judgment" adequately protects the liberty interest of an institutionalized person. *U.S. v. Charters*, ___ F.2d ___ (4th Cir. 1988) en banc, Westlaw No. 86-5568 (Dec. 9, 1988), vacating *U.S. v. Charters*, 829 F.2d 479 (4th Cir. 1987).

After a lengthy and thorough analysis of the prior decisions of this Court, and particularly relying on *Youngberg v. Romeo*, 457 U.S. 307 (1982), the *Charters* court concluded:

The basic principle is that a legally institutionalized mental patient is entitled to the exercise of professional judgment by those who have the responsibility for making medical decisions that affect his retained liberty interest. *Romeo*, 457 U.S. at 321; *Parhan*, 442 U.S. at 607-08. This is the process due such a person in this particular circumstance * * *.

Charters, ___ F.2d at ___.

Further, the *Charters* court held that "[t]he decision [to medicate] may be based upon accepted medical practices in diagnosis, treatment and prognosis, with the aid of such technical tools and consultative techniques as are appropriate in the profession." *Id.* at ___. In addition, "the basis for the decision should be supported by adequate documentation, not only because of normal professional requirements, but as a potential aid to judicial review." *Id.* at ___.

As to the necessity of judicial involvement, the *Charters* court concluded:

The "professional judgment" standard also dictates the scope of judicial review. Under that standard, the question presented by a judicial challenge such as *Charters* is not whether the treatment decision was the medically correct or most appropriate one. *It is only whether the decision was made by an appropriate professional in the exercise of professional judgment, i.e. not arbitrarily* * * *. Due process is denied under this standard only if the decision was reached by such a "substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment."

Id. ___ F.2d at ___, citations and footnote omitted, (emphasis added).

To the contrary, the court below held that federal due process required a judge, and not a medical professional, to make the ultimate medical decision as to whether the proposed administration of involuntary medications would be necessary and effective. Further, the court below required that such a decision be based on clear, cogent and convincing evidence — a standard certainly more demanding than the *Charters* requirement that professional judgment in fact be exercised.

Thus, the decision below purporting to interpret Fourteenth Amendment due process requirements in the context of this § 1983 lawsuit is a clear departure from the teachings not only of this Court, but of the circuit courts which have addressed the issue. For these reasons, this Court should accept certiorari and reverse the decision of the court below.

DATED This 2nd day of February, 1989.

Respectfully submitted,

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JOINT APPENDIX

No. 88-599

Supreme Court, U.S.

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OCTOBER TERM, 1988

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ON WRIT OF CERTIORARI
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JOINT APPENDIX

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PETITION FOR WRIT OF CERTIORARI
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MARCH 6, 1989

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**CHRONOLOGICAL LIST OF RELEVANT
PROCEEDINGS BELOW**

1. February 5, 1985 — Respondent Walter Harper files his 42 U.S.C. § 1983 Complaint seeking declaratory, injunctive and monetary relief, alleging his constitutional rights have been violated as a result of the involuntary administration of antipsychotic medication. The complaint is filed in the Superior Court of the State of Washington for the County of Snohomish. Docket No. 85-2-00394-1.
2. April 1, 1985 — Petitioners file their Answer to respondent's Complaint.
3. May 9, 1986 — Respondent Harper amends his Complaint to name all individual defendants in their individual capacity as well as their official capacity.
4. March 9-10, 1987 — A trial is conducted in the Superior Court of the State of Washington for the County of Snohomish. The Superior Court gave its oral opinion on March 10, 1987, in favor of the defendants-petitioners.
5. May 12, 1987 — Snohomish County trial court enters Findings of Facts and Conclusions of Law and grants judgment in favor of defendants.
6. June 19, 1987 — Respondent Harper files his Notice of Appeal to the Washington State Supreme Court. The Notice of Appeal was filed in the Snohomish County Superior Court.
7. February 24, 1988 — Oral argument is held before the Washington State Supreme Court. Docket No. 54045-4.
8. July 7, 1988 — The opinion of the Washington State Supreme Court is filed.
9. August 2, 1988 — The Washington State Supreme Court mandates the cause to the Snohomish County Superior Court for further proceedings in accordance with the opinion.
10. October 5, 1988 — The Petition for Writ of Certiorari is filed. Docket No. 88-599.
11. March 6, 1989 — The Writ of Certiorari is granted by the United States Supreme Court.

The following Findings of Fact and Conclusions of Law; and Opinion of the Washington Supreme Court have been omitted in printing this joint appendix because they appear on the following pages in the appendix to the printed Petition for Certiorari:

Findings of Fact and Conclusions of law in the Superior Court of the State of Washington dated May 12, 1987 B-1

Opinion of the Supreme Court of the State of Washington, entered on July 7, 1988 A-1

IN THE SUPERIOR COURT OF THE STATE OF
WASHINGTON IN AND FOR SNOHOMISH
COUNTY

No. 85-2-00394-1

COMPLAINT FOR DECLARATORY, INJUNCTIVE
RELIEF AND MONETARY DAMAGES

WALTER HARPER,

Plaintiff,

v.

STATE OF WASHINGTON; JOSEPH LEHMAN, Assistant Director, Washington State Division of Prisons; KENNETH DuCHARME, Superintendent, Washington State Reformatory (Monroe); HERBERT MARRA, Superintendent, Washington State Special Offender Center (Monroe); JOHN PETRICH, M. D., Consulting Psychiatrist, Washington State Special Offender Center (Monroe); TOM ROLFS, Former Superintendent, Washington State Special Offender Center; WILLIAM STARK, Former Associate Superintendent, Washington State Special Offender Center; PHILLIP GILES, Ph. D., JANIESE LOEKEN, M.D., M.C. STORRIE-LOMBARDI, M. D., Washington State Special Offender Center,

Defendants.

INTRODUCTION

This is an action to enjoin defendants from subjecting plaintiff, against his will and without his consent, to the administration of anti-psychotic drugs. Because involuntary hospitalization and/or incarceration does not result in a finding of incompetency, a separate determination must be made as to whether involuntary medication of involuntarily hospitalized and/or incarcerated persons is warranted.

This is an action arising under the Civil Rights Act of 1866, 42 U.S.C. 1983.

II. JURISDICTION

2.1 Jurisdiction is proper in this case since, to the best belief and information of plaintiff, all parties to this action reside in Snohomish County and all actions complained of occurred in Snohomish County.

III. PARTIES

Plaintiff

3.1 Plaintiff Walter Harper is a citizen of the United States and resident of the State of Washington. He is presently incarcerated at the Special Offenders Center (hereinafter SOC), an institution within the Department of Corrections, State of Washington, located at Monroe, Washington.

Defendants

3.2 *State of Washington.*

3.3 *Joseph Lehman.* Defendant Joseph Lehman is the Assistant Director, Washington State Department of Corrections and as such has supervisory power with respect to the Monroe Reformatory (hereinafter Reformatory) and SOC.

3.4 *Kenneth DuCharme.* Defendant Kenneth DuCharme is the Superintendent at the Reformatory and as such has supervisory power with respect to the Reformatory and SOC.

3.5 *Herbert Marra.* Defendant Herbert Marra is the Superintendent at SOC and is responsible for the operations of SOC.

3.6 *John Petrich, M.D.* Defendant John Petrich, M.D. is a consulting psychiatrist at the SOC.

3.7 *Tom Rolfs.* Defendant Tom Rolfs is the former Superintendent of SOC and was responsible for the operations of SOC.

3.8 *William Stark.* Defendant William Stark is the former Associate Superintendent at SOC and as such had supervisory power with respect to SOC.

3.9 *Phillip Giles, Ph.D.* Defendant Phillip Giles, Ph.D. is a consulting psychologist for SOC.

3.10 *Janiese Loeken, M.D.* Defendant Janiese Loeken, M.D., is a psychiatrist employed by SOC.

3.11 *M.C. Storrie-Lombardi, M.D.* Defendant Storrie-Lombardi, M.D. is a psychiatrist employed by SOC.

Status of Defendants

3.12 *Capacity.* All individual defendants are named in their official capacity as employees or contract agents of the Washington State Department of Corrections.

3.13 *Color of Law.* In all relevant actions, defendants were acting under color of law and under color of their authority as employees or contract agents of the Washington State Department of Corrections.

3.14 *Scope of Authority.* In their actions relevant to this suit, defendants exceeded the legitimate scope of their official authority.

IV. FACTUAL ALLEGATIONS

4.1 Plaintiff Walter Harper was transferred to the SOC on January 25, 1982, following parole revocation; he remains incarcerated therein. Prior to his transfer to SOC, plaintiff had been evaluated at Western State Hospital and the Washington Corrections Center. At no time has plaintiff been declared incompetent nor has a guardian ever been appointed for the plaintiff.

4.2 Plaintiff Harper has been and is currently being administered anti-psychotic medications involuntarily. These involuntary medications were initiated on or about November 23, 1982. Acting on a recommendation of de-

fendant Petrich, defendants Stark, Giles, and Loeken convened a hearing at which the plaintiff was present. Defendants Stark, Giles, and Loeken reached the decision that the plaintiff should be involuntarily administered anti-psychotic drugs. The decision of hearing board was reviewed and approved by defendant Rolfs.

4.3 In response to the continual objections by the plaintiff to involuntary medications, SOC has convened numerous committees before which the plaintiff has appeared for review of the medication practice. During several of these reviews, defendants Storrie-Lombardi and Giles approved the continued administration of anti-psychotic medications without the plaintiff's consent and over the plaintiff's objection. Defendant Marra reviewed and approved these decisions. At no time was plaintiff allowed legal counsel or was the decision to involuntarily medicate made by an independent magistrate.

4.4 Due to the extensive adverse effects of anti-psychotic drugs, plaintiff has been frequently changed from one drug to another. The side effects included insomnia, restlessness, headache, hallucinations, dry mouth, blurred vision, tendency to commit suicide and muscle spasms, all of which plaintiff has experienced.

4.5 Defendants further acknowledged their awareness of these adverse side effects by their continual use of and increased dosage of the drug Cogentin. Cogentin is a drug used primarily to relieve the side effects of anti-psychotic drugs. This drug also causes adverse effects. In response to the adverse effects of Cogentin combined with the effects of the anti-psychotic drugs defendants have increased dosages or changed brands of drugs.

4.6 When plaintiff refused to take these drugs orally, defendants would administer them intramuscularly. This caused much pain and humiliation to plaintiff. Plaintiff has been taking the medication orally to avoid this pain and suffering but in no way has this action been voluntary.

V. PLAINTIFF'S CLAIMS

5.1 *Equal Protection.* Plaintiff claims that the administration of anti-psychotic medications against his will and without his consent violates his rights under Article I, Section 12 of the Washington State Constitution and the Fourteenth Amendment to the United States Constitution to the equal protection of the laws. Plaintiff claims that but for his incarceration at SOC, he would have a right to legal counsel and to a hearing before an independent magistrate prior to the involuntary administration of anti-psychotic drugs.

5.2 *Due Process.* Regardless of the standard which defendants may have used to justify the involuntary medication of plaintiff, plaintiff claims that involuntary medication, without an opportunity for a prior hearing before an impartial judge, violates his constitutional right to due process under Article I, Section 3 of the Washington State Constitution and the Fifth and Fourteenth Amendments to the United States Constitution.

5.3 *Freedom of Speech.* Plaintiff claims that the involuntary medication administered violates his constitutional right of freedom of speech and the right to freely generate ideas under Article I, Section 5 of the State Constitution and under the First Amendment to the United States Constitution.

5.4 *Right of Privacy.* The involuntary administration of anti-psychotic drugs constitutes a gross invasion of plaintiff's right of privacy and his right to be free of governmental interference with his body and mind under Article I, Sections 7, 11 and 30 of the Washington State Constitution and the Fourth, Fifth, Ninth, and Fourteenth Amendments to the United States Constitution.

5.5 *Right to Refuse Medical Treatment.* Plaintiff further claims that the administration of anti-psychotic medications against his will violates his State common law right to refuse to consent to medical treatment.

5.6 *Assault and Battery.* The forceful administration of these drugs constitutes the torts of assault and battery under the common law of the State of Washington.

5.7 *Outrage.* Defendants actions constitute the tort of outrage under the common law of the State of Washington.

VI. PRAYER FOR RELIEF

WHEREFORE, plaintiff requests:

6.1 *Declaratory Judgment.* A declaration that the involuntary administration of anti-psychotic medication to the plaintiff is illegal unless an impartial magistrate, following hearing at which time the defendant is represented by counsel, approves of such administration of such medication. And further, that the administration of anti-psychotic medication without such a hearing violates the above-noted constitutional provisions of both the State and Federal constitutions and constitutes the torts of battery and outrage under the common law of the State of Washington.

6.2 *Injunctive Relief.* An injunction permanently restraining, enjoining and prohibiting defendants, their successors, and their agents or employees from administering anti-psychotic drugs to plaintiff without his written consent or unless and until an independent magistrate, following hearing at which time the plaintiff is represented by counsel, determines that such administration of such medication is appropriate.

6.3 *Compensatory Damages.* Judgment in favor of plaintiff against defendants, jointly and severally in amounts to be proven at trial.

6.4 *Punitive Damages.* Judgment in favor of plaintiff against defendants, jointly and severally in amounts to be proven at trial.

6.5 *Costs and Attorney's Fees.* An award of plaintiff's

costs, expenses and reasonable attorney's fees pursuant to 42 U.S.C. Section 1988.

6.6 *Further Relief.* Such additional relief as the Court deems just.

DATED this 1st day of February, 1985.

/s/ BRIAN PHILLIPS
Attorney for Plaintiff

I, Walter Harper, state as follows:

1. I am the plaintiff in the above-captioned action. I am presently an inmate at the Special Offender's Center, at Monroe, Washington.

2. I have reviewed the above complaint for Declaratory, Injunctive Relief and Monetary Damages.

3. I adopt the factual allegations as contained in the complaint and state that to my best belief and information said factual allegations are true and correct.

4. I do not wish to receive anti-psychotic medications.

5. I certify under penalty of perjury under the Laws of the State of Washington that the foregoing is true and correct.

/s/ WALTER HARPER

IN THE SUPERIOR COURT OF THE STATE OF
WASHINGTON IN AND FOR THE COUNTY OF
SNOHOMISH

No. 85-2-00394-1

DEFENDANTS STATE OF WASHINGTON'S ET
AL., ANSWER TO PLAINTIFF'S COMPLAINT FOR
DECLARATION, INJUNCTIVE RELIEF AND
MONETARY DAMAGES.

WALTER HARPER

Plaintiff

vs

STATE OF WASHINGTON, et al.

Defendants

Defendants, State of Washington, et al., in answer to
plaintiff's complaint, admit, deny and allege as follows:

I.

Defendants deny the allegations contained in para-
graph I, except insofar as it states the jurisdictional basis
for this action.

II.

Defendants deny the allegations contained in para-
graph II.

III.

Defendants generally admit the identity of the parties
named in paragraph III of the complaint. Defendants deny
that defendant DuCharme has any supervisory responsi-
bility with respect to Special Offender Center (paragraph
3.4); Defendants deny that defendants Petrich, Giles,
Loeken and Storrie-Lombardi are employed by the Special
Offender Center. Defendants further deny the remainder
of the allegations of paragraph III of the complaint and

specifically deny the allegations of paragraph 3.14 of the
complaint.

IV.

4.1 Defendants admit plaintiff is or has been incar-
cerated at the Special Offender Center in Monroe, Wash-
ington. Defendants are without information sufficient to
form a belief as to the truth of the remainder of the allega-
tions of paragraph 4.1 of the complaint and therefore deny
the same.

4.2 Defendants admit that plaintiff is or has been
administered anti-psychotic medications involuntarily and
affirmatively allege that the same was done pursuant to
approved Department of Corrections policy and applicable
laws. The defendants deny the remainder of the allega-
tions of paragraph 4.2 of the complaint.

4.3 Defendants deny the allegations of paragraph
4.3 of the complaint.

4.4 Defendants are without information sufficient to
form a belief as to the truth of the allegations of paragraph
4.4 of the complaint and therefore deny the same.

4.5 Defendants are without information sufficient to
form a belief as to the truth of the allegations of paragraph
4.5 of the complaint and therefore deny the same.

4.6 Defendants are without information sufficient to
form a belief as to the truth of the allegations of paragraph
4.6 of the complaint and therefore deny the same.

V.

Defendants deny each and every other allegation of
the complaint, not admitted or denied herein.

By way of further answer and affirmative defense, de-
fendants allege as follows:

1. SERVICE OF PROCESS

That the summons and complaint were never prop-
erly served upon the defendants.

2. VENUE

That the county in which this action has been commenced is not the proper venue for said action.

3. JURISDICTION

That the court lacks jurisdiction over the person of the defendants.

4. CLAIM FILING

That the plaintiff has failed to file a claim against the State of Washington as required by RCW 4.92.100 and RCW 4.92.110.

5. RES JUDICATA

That the plaintiff's action against this defendant is barred by the doctrine of res judicata and/or collateral estoppel.

6. EXHAUSTION OF ADMINISTRATIVE REMEDIES

That the plaintiff has failed to exhaust administrative remedies and therefore the action will not lie.

7. INDISPENSABLE PARTY

That the plaintiff has failed to join an indispensable party and therefore the action will not lie.

8. DISCRETIONARY IMMUNITY

That all actions of the defendants, State of Washington, et al, herein alleged as negligence, manifest a reasonable exercise of judgment and discretion by authorized public officials made in the exercise of governmental authority entrusted to them by law and are neither tortious nor actionable.

9. STATUTE OF LIMITATIONS

That the plaintiff's claim is barred by the statute of limitations.

10. FAILURE TO STATE A CLAIM

That the plaintiff has failed to state a claim upon which relief may be granted.

11. GOOD FAITH

That the defendants at all times acted in good faith in the performance of their duties and are therefore immune from suit for the matters charged in plaintiff's complaint.

12. PRIVILEGE

That the conduct of the defendants was privileged and nontortious.

13. LACHES

That any recovery by plaintiff is barred by reason of laches.

WHEREFORE, defendants pray that plaintiff's complaint be dismissed with prejudice all defendants and that plaintiff take nothing by his complaint and that defendants be allowed their costs and reasonable attorneys' fees herein.

DATED this 27th day of March, 1985.

Respectfully submitted,

/s/ KATHLEEN D. MIX
Assistant Attorney General

SUPERIOR COURT OF WASHINGTON FOR
COUNTY OF SNOHOMISH

No. 85-2-00394-1

JUDGMENT

WALTER HARPER,

Plaintiff,

vs.

STATE OF WASHINGTON, et al.,

Defendants.

THIS MATTER came for trial on March 9th and 10th, 1987, before the undersigned judge of the above-entitled court. Plaintiff appeared by and through his attorney Brian Reed Phillips, defendants appeared by and through their attorneys Kenneth O. Eikenberry, Attorney General and Michael Madden, Assistant Attorney General. The parties stipulated that defendants answers to plaintiff's interrogatories, and exhibits thereto, could be considered by the Court as substantive evidence and the Court has considered those documents. Further, the Court heard the testimony of defendant Dr. John Petrich and of Jerry Minaker, Mental Health Director for the Department of Corrections. Having heard and considered this evidence, and having heard the arguments of counsel, the Court gave its oral opinion on March 10, 1987, in favor of defendants.

Now, THEREFORE, in accordance with Civil Rule 58, it is HEREBY ORDERED ADJUDGED AND DECREED that

Plaintiff's Complaint is dismissed with prejudice;

That judgment is granted in favor of defendants and plaintiffs shall take nothing hereby; and

Defendants are entitled to their costs and disbursements in accordance with law.

DONE IN OPEN COURT this 12th day of May, 1987.

/s/ DANIEL T. KERSHNER
Judge

Presented by:

KENNETH O. EIKENBERRY
Attorney General

/s/ MICHAEL MADDEN
Assistant Attorney General
Attorneys for Defendant
State

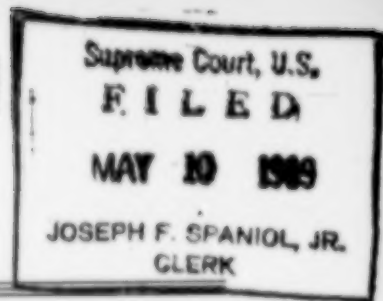
Approved as to form and notice
of presentation waived:

/s/ BRIAN REED PHILLIPS
Attorney for Plaintiffs

PETITIONER'S

BRIEF

No. 88-599



IN THE
SUPREME COURT
OF THE
UNITED STATES

OCTOBER TERM, 1988

STATE OF WASHINGTON, et al.,

Petitioners,

v.

WALTER HARPER,

Respondent.

ON WRIT OF CERTIORARI TO
THE SUPREME COURT OF THE STATE OF
WASHINGTON

BRIEF OF PETITIONERS

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4099

QUESTIONS PRESENTED

I. Is an incarcerated felon constitutionally entitled to a judicial hearing and attendant adversarial procedural protections prior to the involuntary administration of medically prescribed antipsychotic medication?

II. If an incarcerated felon possesses a constitutionally protected liberty interest in refusing medically prescribed antipsychotic medication, must the State prove a compelling state interest to administer antipsychotic medication or does the "reasonable relation" standard of *Turner v. Safley*, — U.S. — 107 S. Ct. 2254 (1987), control?

LIST OF PARTIES

The parties to the proceeding below were: Petitioners, State of Washington; Joseph Lehman, former Assistant Director of the Division of Prisons of the Washington State Department of Corrections, now Deputy Secretary of the Department of Corrections; Kenneth DuCharme, Superintendent, Washington State Reformatory; Herbert Marra, former Superintendent of the Washington State Special Offender Center; John Petrich, formerly a consulting psychiatrist to the Washington State Special Offender Center; Tom Rolfs, former Superintendent of the Washington State Special Offender Center, now Assistant Director of the Division of Prisons; William Stark, former Associate Superintendent of the Washington State Special Offender Center; Phillip Giles, Ph.D., Janiese Loeken, M.D., M.C. Storrie-Lombardi, M.D., all former employees of the Washington State Special Offender Center. The above parties were aligned as Defendants-Respondents below.

Respondent Walter Harper, an inmate serving a sentence in the Washington State Prison system, was aligned as the Plaintiff-Appellant below.

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No. 88-599

IN THE
SUPREME COURT
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OCTOBER TERM, 1988

STATE OF WASHINGTON, et al.,

Petitioners,

v.

WALTER HARPER,

Respondent.

ON WRIT OF CERTIORARI TO
THE SUPREME COURT OF THE STATE OF
WASHINGTON

OPINIONS BELOW

The opinion filed on July 7, 1988, by the Washington State Supreme Court, reversing and remanding the Snohomish County Superior Court's decision dismissing respondent Harper's 42 U.S.C. § 1983 complaint, is found at *Harper v. State*, 110 Wn.2d 873, 759 P.2d 358, (1988) and appears in the petition for certiorari at Appendix A (Pet. A). The Findings of Fact and Conclusions of Law of the Superior Court of the State of Washington which granted judgment in favor of the defendants-petitioners appear in the Petition for Certiorari at Appendix B (Pet. B). The Judgment of the Snohomish County Superior Court dismissing plaintiff-respondent's Complaint with prejudice and granting judgment in favor of defendants appears in the Joint Appendix at p. 14. (J.A. 14).

JURISDICTION

The Washington State Supreme Court filed its opinion reversing the Snohomish County Superior Court's decision dismissing Respondent's 42 U.S.C. § 1983 complaint on July 7, 1988. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(3). The petition for certiorari was filed with this Court on October 5, 1988. This Court granted the writ of certiorari on March 6, 1989.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Fourteenth Amendment to the United States Constitution, Section 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

42 U.S.C. § 1983. Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

STATEMENT OF THE CASE

Respondent Harper was convicted of robbery in 1976, and sentenced to prison. Finding of Fact 4, Pet. B-4.¹ In De-

¹The trial court's Findings of Fact and Conclusions of Law are set forth in their entirety as Appendix B to the Petition. Respondent Harper did not challenge these findings of fact, and under Washington law, they are accepted as verities on appeal. *Metropolitan Park Dist. v. Griffith*, 106 Wn.2d 425, 433, 723 P.2d 1093 (1986).

cember, 1980, he was released on parole by the Board of Prison Terms and Paroles. *Id.* In December, 1981, he assaulted two nurses at Cabrini Hospital, in Seattle, Washington. *Id.* This incident formed the basis for revocation of his parole, and he was returned to prison. *Id.*

Upon his return to the custody of the Washington State Department of Corrections, Harper was assigned to the Special Offender Center, a Department of Corrections prison having special staffing and facilities for inmates with mental or behavior disorders. Finding of Fact 5, Pet. B-4; Finding of Fact 2, Pet. B-2.²

While at the Special Offender Center, Harper was treated by Dr. John Petrich, a defendant below and one of the petitioners herein. Finding of Fact 5, Pet. B-4, B-5. From January to February of 1982 and from May to November of 1982, Harper cooperated with that treatment. *Id.* Dr. Petrich diagnosed Harper as suffering from manic depression, schizoaffective disorder, or schizophrenia. *Id.* During this time period, Harper voluntarily took the antipsychotic medications prescribed by Dr. Petrich as part of his treatment. *Id.* However, in November 1982, Harper indicated that he would no longer voluntarily take the antipsychotic medications which Dr. Petrich had prescribed for him. *Id.*

Special Offender Center Policy 600.30³ limits the cir-

²As found by the trial court, the function of the Special Offender Center "is to provide diagnosis and treatment of convicted felons sentenced to prison * * * with the goal of allowing behaviorally or mentally disturbed inmates to attain a level of functioning such that they can be transferred to one of the other correctional institutions of the state to serve their sentence." Finding of Fact 2, Pet. B-2. The trial court also found that Harper's "history includes incidents of assaultive behavior." Finding of Fact 5, Pet. B-5. Indeed, the uncontroverted evidence before the trial court included numerous documented instances of Harper's unprovoked assaults on staff and other inmates, physical and verbal harassment of staff and inmates, and, on at least four occasions, setting fire to mattresses and clothing while confined to his own cell. See generally, Book 1, materials supplied in response to Request for Production 4f and 4g, C.P. 79-111, considered by the trial court as substantive evidence pursuant to a stipulation of the parties. Introductory paragraph to Findings of Facts and Conclusions of Law, Pet. B-1.

³The policy underwent several revisions during the time period of Harper's treatment. The last revision, effective February 18, 1985, was as-

cumstances under which antipsychotic medication⁴ can be administered involuntarily. Finding of Fact 3, Pet. B-3. Under that policy, a prisoner may be involuntarily medicated only if he suffers from a mental disorder and as a result of that is either gravely disabled or presents a likelihood of serious harm to himself or others. *Id.* Such medications must be either ordered or approved by a psychiatrist. *Id.* If the patient refuses the medication, a special hearing committee, consisting of a psychiatrist, a psychologist, and the Associate Superintendent of the prison, is convened for the purpose of conducting a hearing to determine whether the involuntary administration of antipsychotic medications is warranted in the particular case. *Id.*

Under the policy, the patient has certain procedural rights prior to the hearing. These include 24 hours notice of the hearing — during which time he may not be medicated — notice of the tentative diagnosis and the factual basis for that diagnosis, and notice of the basis upon which medical treatment is necessary. *Id.*

Further, the policy provides that at the hearing, the prisoner has the right to be present, to present evidence, to

signed a new number — 620.200. However, the major elements of the policy remained intact from one revision to the next. For the most part, the trial court and the Washington Supreme Court treated the policy as a singular constant, and petitioners do likewise herein.

⁴The policy by its terms was addressed only to "psychiatric medication," a term which it did not define. See Book 1⁰, materials supplied in response to Plaintiff's Interrogatory 6, C.P. 79-111. The trial court found that Harper had "both voluntarily and involuntarily * * * received a variety of antipsychotic drugs, including Trialafon; Haldol; Prolixin; Taractan; Loxitane; Mellaril; and Navane," and couched its discussion in terms of "these medications." Finding of Fact 9, Pet. B-7. The Washington Supreme Court used a more expansive definition. Pet. A-4, n.3. As discussed more fully in Part III below, the Washington Supreme Court's categorization is questionable at best. See, *infra* p. 20, n. 13. The Washington Legislature, in attempting to engraft the requirements of the Harper decision onto the state's civil commitment procedure, used the following definition: "'Antipsychotic medications', also referred to as 'neuroleptics', means that class of drugs primarily used to treat serious manifestations of mental illness associated with thought disorders and currently includes phenothiazines, thioxanthes, butyrophenone, dihydroindolone, and dibenzoxazine." Chapter 120, Washington Laws of 1989, § 2.

present his own witnesses, and cross-examine staff witnesses. *Id.* The prisoner is entitled to a non-lawyer advisor who has not been involved with the case and who has an understanding of the psychiatric issues in the case. *Id.*

The policy provides that none of the committee members may currently be involved in treatment or diagnosis of the patient. *Id.* After reviewing the evidence presented to it by institution staff and by or on behalf of the prisoner, the committee decides, based on a majority vote, whether the patient is gravely disabled or dangerous. *Id.* If medication is to be approved, the psychiatrist must vote with the majority. *Id.* Minutes of the hearing are kept and the prisoner has the right to appeal to the Superintendent of the prison. *Id.* As the trial court observed, the decision is also subject to judicial review by personal restraint petition (See Washington Rules of Appellate Procedure 16.3-16.15) or by extraordinary writ in the superior court. Conclusion of Law 2, Pet. B-8.

When Harper began in November, 1982, to refuse to take the prescribed antipsychotic medication, Dr. Petrich requested that a hearing committee be convened pursuant to Special Offender Center Policy 600.30. Finding of Fact 6, Pet. B-5. The members of that committee were defendants below and are petitioners herein. *Id.* The hearing was in fact conducted in accordance with the policy. Finding of Fact 13, Pet. B-8. Harper was present and was assisted by a nurse-practitioner from a different prison operated by the Department. Finding of Fact 6, Pet. B-5. Based on the evidence before it, the committee found that Harper was a danger to others as a result of a mental disease or disorder, and authorized the involuntary administration of antipsychotic medication to Harper. *Id.*

Under Policy 600.30, once the involuntary administration of antipsychotic medication has been authorized, it can only continue if certain administrative and medical reviews are conducted. As in effect at the time that Harper was first involuntarily medicated, in November 1982, the policy required another review by the hearing committee seven days after the initial treatment, and if further medication was approved, a written medical review every fourteen days. Find-

ing of Fact 3f, Pet. B-4. The written medical reports were submitted to the Medical Director for the Department of Corrections at Department headquarters. *Id.*

Harper continued to receive treatment, including the involuntary administration of antipsychotic medication, at the Special Offender Center until November, 1983, when he was transferred to the Washington State Reformatory, another prison operated by the Department. Finding of Fact 6b, Pet. B-6. Following his transfer, he discontinued taking the prescribed medications, his condition deteriorated, he decompensated, and he was returned to the Special Offender Center on December 22, 1983. *Id.*

On December 30, 1983, another hearing was convened pursuant to Special Offender Center Policy 600.30 to determine whether involuntary treatment with antipsychotic medications should once again be authorized for Harper. Finding of Fact 6c, Pet. B-6. The hearing was conducted in accordance with the policy, and the committee approved the treating physician's recommendation to resume the involuntary administration of antipsychotic medication. *Id.*

Harper remained at the Special Offender Center for approximately two and one-half years, until June, 1986, when he was transferred to the Washington State Penitentiary. Finding of Fact 6d, Pet. B-6. During that time period, he continued to be treated, including the involuntary administration of antipsychotic medication, pursuant to Policy 600.30. *Id.* At all times, he received the required medical reviews and hearings under the policy, and was accorded all procedural rights prescribed by the policy. *Id.*

On February 1, 1985, while he was still confined at the Special Offender Center, Harper initiated the instant litigation. In his Complaint, brought under 42 U.S.C. § 1983, Harper claimed, inter alia, that the involuntary administration of antipsychotic drugs pursuant to Special Offender Center Policy 600.30 violated both the due process and equal protection clauses of the state and federal constitutions, and also constituted torts under state law. J.A. 8.

A non-jury trial was conducted in the Snohomish County Superior Court on March 9 and 10, 1987. See intro-

ductory paragraph to Findings of Fact, Pet. B-1. Two witnesses — Dr. Petrich and Jerry Minaker, the Mental Health Director for the Department of Corrections — testified. *Id.* In addition, the parties stipulated that the court could consider the defendants' answers to plaintiff's two sets of Interrogatories, and the exhibits thereto, as substantive evidence. *Id.*

The trial court found that Harper did have a due process protected liberty interest in being free from the involuntary administration of antipsychotic medications, but that Special Offender Center Policy 600.30 provided adequate procedural protections for that liberty interest. Conclusions of Law 1, 3, Pet. B-8, 9. Accordingly, the complaint was dismissed. J.A. 14.

Harper appealed to the Washington Supreme Court, which reversed the trial court's decision, holding that the Constitution required a judicial hearing with the full panoply of attendant components — including the right to legal counsel and to expert witnesses — prior to involuntary treatment with antipsychotic medications. The Court also held that such treatment could only be authorized upon a showing, by clear, cogent and convincing evidence, of a compelling state interest. *Harper v. State*, 110 Wn.2d 873, 759 P.2d 358 (1988). It is from that holding that petitioners herein seek relief.⁵

SUMMARY OF ARGUMENT

The decision of the Washington Supreme Court — by mandating a judicial hearing before involuntary treatment with antipsychotic medications — goes far beyond what this Court has previously required in the context of involuntary treatment. Imposing this requirement in a prison context

⁵The Washington Supreme Court acknowledged that "[a]t the time of the State's action at issue in this case, the law regarding prisoners' rights to refuse antipsychotic drug treatment was not clearly established," and therefore held the defendants to be immune from liability for monetary damages under *Harlow v. Fitzgerald*, 457 U.S. 800 (1982), and its progeny. Respondent has not cross-petitioned on this holding and it is therefore not before the Court in this case.

flies in the face of this Court's holdings in previous decisions addressing the constitutional rights of convicted felons.

Moreover, the decision below is based on a faulty analysis of the medical literature concerning antipsychotic medications. The Washington Supreme Court has ignored the recognized beneficial effects of treatment with such medication, as well as the adverse consequences of foregoing such treatment, even temporarily. The court below also exaggerated the significance and likelihood of possible side effects.

Finally, by unnecessarily diverting to the judiciary what are essentially medical decisions, the Washington Supreme Court has undercut the ability of prison administrators to provide appropriate medical care for the benefit of inmates and the protection of the public.

ARGUMENT

- I. **Assuming that a state prisoner has a liberty interest in refusing treatment with medically prescribed antipsychotic medications, the process outlined in Special Offender Center Policy 600.30 satisfies the procedural due process requirements of the Fourteenth Amendment to the United States Constitution.**

Since respondent's claim is brought under 42 U.S.C. § 1983, it is axiomatic that in order to prevail he must demonstrate that defendants have deprived him of a federal constitutional right. In this case, respondent must show: (1) that he had a liberty interest in refusing involuntary treatment with medically prescribed antipsychotic medication; and (2) that the defendants deprived him of that right without due process of law. If either proposition is not established, his claim must fail.

Petitioners, on the other hand, need only demonstrate that the process provided by Policy 600.30 satisfies the due process clause of the Fourteenth Amendment, even if there

does exist a protected liberty interest in refusing treatment.⁶

Since petitioners prevail if — as they assert — Special Offender Center Policy 600.30 provides adequate due process, petitioners will assume the existence of such a liberty interest for the purposes of this part of the argument.

A. Past decisions of this Court in analogous cases support petitioners' position that Special Offender Center Policy 600.30 accorded Harper adequate due process protection.

The precise issue presented by this case — the due process required before an incarcerated felon can be involuntarily treated with medically prescribed antipsychotic medication — has never been before this Court. There are, however, a series of cases involving issues sufficiently analogous to give guidance as to the resolution of this case. In none of these situations has the Court required as high a level of due process as that provided by Special Offender Center Policy 600.30.

An analysis of the Court's recent teachings regarding due process in the context of involuntary commitment and treatment begins with *Parham v. J.R.*, 442 U.S. 584 (1979). *Parham* was a 42 U.S.C. § 1983 lawsuit challenging Georgia's voluntary commitment procedures for children under the age of eighteen.⁷ The *Parham* analysis dealt with two different groups of children, those who were in the custody of their parents or guardians and those who were essentially wards of

⁶In Part II, *infra* p. 18, petitioners argue that in fact no such liberty interest exists, at least in the United States Constitution. Significantly, although the Superior Court in this case concluded that a liberty interest existed, it did not identify the exact source of that liberty interest. Conclusion of Law 1, Pet. B-8.

⁷Georgia law essentially allowed such commitment upon the consent of the parent or guardian, subject to a medical determination — after a short period of evaluation — that (1) there was "evidence of mental illness" and that (2) the child was "suitable for treatment." *Id.* at 591. No hearing process was mandated, and the court noted that in fact admission and discharge practices varied from one hospital to the next. *Id.* at 592.

the state, but did not find it necessary to distinguish between the two groups in its due process analysis. *Id.* at 619.⁴

The *Parham* Court rejected the argument that due process required a formal hearing process involving a trier of fact trained in law or a judicial or administrative officer. *Id.* at 608. "[N]either judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments." *Parham* at 609 citing *In re Roger S.*, 19 Cal.3d 921, 942, 141 Cal.Rptr. 298, 311, 569 P.2d 1286, 1299 (1977) (Clark, J. dissenting).

The *Parham* Court noted that evaluating the appropriateness of medical diagnostic procedure is not properly the business of judges. *Id.* at 609. Realizing that the appropriate questions were essentially medical in character, that is — whether the child was mentally or emotionally ill and whether he could benefit from treatment provided by the state — the Court reiterated that the determination of whether that person was mentally ill "turns on the meaning of the facts which must be interpreted by expert psychiatrists and psychologists." *Parham* at 610 (quoting *Addington v. Texas*, 441 U.S. 418 at 429 (1979)).

The *Parham* Court acknowledged the possible fallibility of medical and psychiatric diagnosis, but yet would not accept the notion that the shortcomings of these specialists could be avoided by shifting the decision-making to a judicial arena. *Parham* at 608-609. As the *Parham* Court observed: "Even after a hearing, the nonspecialist decision-maker must make a medical-psychiatric decision. Common human experience and scholarly opinion suggests that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real." *Id.* at 610.

The Court next examined the procedural protections applicable prior to committing an individual to a mental hospital for involuntary treatment in *Vitek v. Jones*, 445 U.S.

⁴The Court found the existence of a liberty interest in not being confined unnecessarily for medical treatment to be "not disputed." *Id.* at 600.

480 (1980). In *Vitek*, the Court addressed the due process rights of a Nebraska prison inmate facing transfer to a non-prison mental hospital for treatment for his mental illness. *Id.* at 483.

The *Vitek* Court held that procedural due process protections were required, including notice, an independent decision maker, non-lawyer assistance, presence at the hearing, and a written record and opportunity to present evidence.

In the instant case, the state trial court held that the Special Offender Center's involuntary medication policy was consistent with the *Vitek* requirements and met constitutional standards. Conclusion of Law 3, Pet. B-3. Indeed, the trial court noted that the policy was first developed after the *Vitek* decision, and adopted after consideration of its impact. Finding of Fact 3, Pet. B-3.

The most directly applicable teachings from this Court regarding the involuntary treatment of a confined individual came in *Youngberg v. Romeo*, 457 U.S. 307 (1982). There the Court dealt with the level of due process required before a mentally retarded person could be physically restrained. *Youngberg* at 310. The *Youngberg* Court adopted the "professional judgment" standard to provide the proper balancing of legitimate state interests and the rights of the involuntarily committed.

The *Youngberg* Court agreed with the federal trial court judge that " * * * the Constitution only requires that the courts make certain that professional judgment, in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made." *Youngberg* at 322, (quoting C.J. Seitz, *Romeo v. Youngberg*, 644 F.2d 147, 178 (3rd Cir. 1980)).

While determining what the Constitution reasonably requires, the *Youngberg* Court also emphasized the need to show deference to qualified professional judgment, noting that by so limiting judicial review, interference by the federal judiciary with institution operation would be minimized. *Id.* Further, the *Youngberg* Court reiterated that "there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such

decisions." *Youngberg* at 323, 324 (citing *Parham*, 442 U.S. at 607).

A less direct but nonetheless significant indicator of the Court's approach to the issue in this case, is the action of the Court in remanding *Rennie v. Klein*, 458 U.S. 1119 (1982) in light of *Youngberg*. On remand, the Third Circuit held that a judicial hearing was not required prior to the nonconsensual administration of antipsychotic medication to involuntarily committed mental patients. Using the *Youngberg* rationale, the *Rennie* court found that the administrative procedures adopted by New Jersey, were adequate to protect the patient's constitutional rights. *Rennie v. Klein*, 720 F.2d 266 (3rd Cir. 1983).

In none of these cases was the level of due process required by the Court before implementation of a treatment decision higher than that provided under Special Offender Policy 600.30. In fact, only in one case — *Vitek* — did the level of due process required by the Court even approach that accorded Harper.

The Washington Court recognized as much when it denied Harper monetary damages since the rule of law it announced was not previously "clearly established." Pet. A-12.

Thus the decision below goes beyond anything required by the past decisions of this Court.

B. Recent teachings of this Court regarding the constitutional claims of prisoners also support the adequacy of Policy 600.30.

Respondent Harper is a felon incarcerated in the Washington State Department of Corrections. Harper does not contest the validity of his confinement or his initial transfer to the Special Offender Center. Nor does Harper contend that the State of Washington did not follow the Special Offender Center's involuntary medication policy. Rather, he contends that the policy fails to provide adequate due process protection because it allows the state to decide to administer antipsychotic medication against his will, without a judicial hearing. Pet. A-5.

There can be no doubt that Mr. Harper's valid criminal conviction and prison sentences extinguish his right to freedom from confinement. *Greenholtz v. Inmates of Nebraska Penal and Correctional Complex*, 442 U.S. 1, 7 (1979). A valid conviction and sentence also "sufficiently extinguishes a defendant's liberty 'to empower the State to confine him in any of its prisons.'" *Vitek v. Jones*, 445 U.S. 480, 494, (1980) (quoting *Meachum v. Fano*, 427 U.S. 215, 224 (1976)).

While analyzing the rights of a convicted felon, the Court has balanced the constitutional protection to be afforded convicted felons against penal institutional needs and objectives which necessarily restrict the convicted felons' rights due to "the nature of the regime to which they have been lawfully committed." *Wolff v. McDonnell*, 418 U.S. 539, 557 (1974). " 'Lawful incarceration brings about the necessary withdrawal or limitation of many privileges and rights, a retraction justified by the considerations underlying our penal system.' [citations omitted] * * * The fact of confinement as well as the legitimate goals and policies of the penal institution limit these retained constitutional rights [citations omitted]." *Bell v. Wolfish*, 441 U.S. 520, 546-547 (1979).

Convicted felons retain significant constitutional protections or interests, but these interests are not absolute. Those constitutional protections retained by convicted felons must be balanced against legitimate governmental interests which are incidental to legal confinement, therefore felons are only afforded protection against arbitrary and capricious government action.

The obligation of those delegated the responsibility for administering our nation's prisons includes the duty of protecting those inmates so incarcerated as well as the personnel who are employed in those institutions. This obligation must be met while obeying the Eighth Amendment's proscription against cruel and unusual punishment. *See generally, Estelle v. Gamble*, 429 U.S. 97 (1976). This Court's Eighth Amendment teachings indicate that convicted felons have a right to adequate medical care. *Id.* The right to medical care also includes the right to psychological or psychiatric care. *Bowring v. Godwin*, 551 F.2d 44 (4th Cir. 1977).

It is in the context of balancing the rights provided by the Constitution, including the Eighth Amendment, and the realities of administering a prison and fulfilling societal objectives, that the rights of a convicted felon must be considered. As put succinctly by Chief Judge Seitz in his concurring opinion in *Rennie v. Klein*, 720 F.2d 266 (3rd Cir. 1983):

The justification for the administration of the antipsychotic drugs is not unrelated to this question of the State's confinement of the patient. Where the State has removed that patient from society because he is dangerous, it is empowered to make additional decisions that affect his welfare. * * * [T]he power to make these decisions is supported by the dual interest in society's and the patient's welfare. The State is not restricted to helping the patient only if he wishes to be helped. That limitation was overcome when the patient was confined.

Id. at 273. Judge Seitz' observation is no less pertinent in the case of a convicted felon than in that of an involuntarily civilly committed patient.

Of the four cases discussed, in sub part A above, only one — *Vitek* — involved a state prisoner, and the issue there was transfer to a mental hospital, not treatment in a prison. The other cases — *Parham*, *Youngberg*, and *Rennie* — indicate that adequate due process is provided non-prisoners by the exercise of professional medical judgment. Yet the most recent case from this Court outlining the contours of the constitutional rights of incarcerated felons indicates that, if anything, lesser procedural protections may be required in the prison context.

In *Turner v. Safley*, ___ U.S. ___, 107 S.Ct. 2254 (1987), the Court held that "when a prison regulation impinges on an inmate's constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests." *Id.* at 2661. The *Turner* Court found such a standard to be necessary "if prison administrators * * * and not the courts [are] to make the difficult judgment concerning institutional operations." *Turner* at 2261, quoting *Jones v. North Carolina Prisoners' Labor Union*, 433 U.S. 119, 128 (1977).

The *Turner* Court was concerned with First Amend-

ment issues, an area traditionally rigorously scrutinized and in which individual rights are fiercely protected. Nonetheless, the *Turner* Court used very broad language which indicates the Court intended the "reasonable relation" analysis to apply to the scrutiny of all prison policies. See *Turner* at 2261. The court below, in contrast, rejected the "reasonable relation" analysis in the instant case. Pet. A-10, n. 9.⁹ The case at bar presents the question of whether the *Turner* "reasonable relation" analysis should apply in examining the constitutionality of an involuntary medication policy.¹⁰

⁹The Washington State Supreme Court's statement that the "reasonable relation" analysis was argued for the first time by the state in its reply to the Brief of Amicus Curiae below is incorrect and misleading. Pet. A-9, n. 9. On December 15, 1987, after the parties had completed normal briefing, the Washington State Supreme Court requested that the parties file supplemental briefs, not to exceed eight pages, on the applicability of a previously unbriefed case, *In re Schuoler*, 106 W.2d 500, 723 P.2d 1103 (1986). In response, Mr. Harper's counsel filed a supplemental brief in which he argued that *Schuoler* was not distinguishable from the instant case. Mr. Harper did not specifically argue that a "compelling state interest" must be shown to legitimize the administration of antipsychotic medication against Mr. Harper's will. In response, petitioners argued that *Schuoler* was inapplicable due to the nature of treatment at issue in that case (electro-convulsive therapy). Petitioners also asserted that the "compelling state interest" analysis utilized in *Schuoler* was perhaps not appropriate in the context of the instant case, citing *Turner* and *O'Lone*. Because of the page limitation set by the Washington State Supreme Court (eight pages), petitioners at that time indicated that a "reasonable relation" analysis would be included in response to subsequent briefing then pending by amicus. Defendants' Supplemental Brief, p. 3.

In a subsequent amicus brief, the compelling state interest argument was first advanced. In response, petitioners did fully assert and argue the applicability of the *Turner* "reasonable relation" analysis. See Defendants' Answer to Brief of Amicus Curiae, as well as Brief of Amicus Curiae.

¹⁰The *Turner* Court used very broad language which indicates the Court intended the "reasonable relation" analysis to apply to the scrutiny of all prison regulations. See *Turner* at 2261. The Circuit Courts of Appeals have applied the "reasonable relation" analysis in contexts other than the First Amendment context of *Turner v. Safley*, *supra* and the companion case of *O'Lone v. Estate of Shabazz*, ___ U.S. ___, 107 S.Ct. 2400 (1987). See *Kent v. Johnson*, 821 F.2d 1220 (6th Cir. 1987), involving prisoner claims under the First, Fourth, Eighth, and Fourteenth Amendments; *Michenfelder v. Sumner*, 860 F.2d 328 (9th Cir. 1988), *Turner* applied in a Fourth and Eighth Amendment context. The court below, in contrast, rejected the "reasonable relation" analysis in the instant case, distinguishing the First Amendment rights involved in *Turner* and *O'Lone*.

It must be remembered that the purpose of the Due Process Clause is not to create artificial barriers to the performance of legitimate governmental functions — rather it merely serves to prevent arbitrary or capricious governmental actions. It is axiomatic that a policy “reasonably related” to a legitimate penological goal is neither arbitrary nor capricious — thus the *Turner* analysis serves the same objective as the Due Process Clause. That being the case, there is no reason the *Turner* analysis should not apply to the case at bar.

C. Special Offender Center Policy 600.30 is adequate to protect any liberty interest a prisoner may have in refusing treatment with medically prescribed antipsychotic medication.

Assuming *arguendo* that an incarcerated prisoner retains a liberty interest in refusing treatment with antipsychotic medications, the procedures outlined in Policy 600.30 strike an appropriate balance between that interest and the state’s interest in operating its prison system in a safe and efficient manner.

Under the policy, involuntary administration of antipsychotic medication is very limited. It can only be administered if: (1) the prisoner suffers from a mental disorder; (2) as a result of the mental disorder he is either gravely disabled or presents a likelihood of serious harm to himself or others; (3) it has been ordered or approved by a psychiatrist. Finding of Fact 3, Pet. B-3. Thus the assurance required by *Parham* and *Youngberg* that “professional judgment in fact [be] exercised” is given. *Youngberg*, 457 U.S. at 322.

Further, an involuntary treatment program can be implemented under Policy 600.30 only after it has been reviewed and approved by a hearing committee, consisting of a psychiatrist, a psychologist and the Associate Superintendent. Finding of Fact 3, Pet. B-3.

The hearing process under the policy includes all of the elements found necessary in *Vitek* — an independent decision-maker, notice, opportunity to present witnesses and testimony, assistance of independent lay advisor and an

adequate record to provide for judicial review. Finding of Fact 3c, d, and e, Pet. B-3.

Moreover, the policy goes beyond the *Vitek* requirements by providing periodic administrative reviews with reports to the Department’s Medical Director. Finding of Fact 3f, Pet. B-4. Not only does this provide an enhanced procedural protection not contemplated by *Vitek*, it gives further assurance that the exercise of professional judgment is ongoing.

Finally, there can be little doubt that Policy 600.30 furthers legitimate penological goals by treating those inmates who are gravely disabled or present a danger to themselves or others. The policy assists prison administrators in meeting their “unquestioned duty to provide reasonable safety for all residents and personnel within the institution.” *Youngberg*, 457 U.S. at 325.

Likewise, the policy facilitates the institutional goal of restoring inmates to “a level of functioning such that they can be transferred to one of the other correctional institutions of the state to serve their sentence.” Finding of Fact 2, Pet. B-2. Thus it promotes the efficient operation of the state’s prison system, one of the factors properly considered under the reasonable relationship test of *Turner* and *O’Lone*.

Indeed, the procedure utilized below appropriately protects all citizens, whether they be civil committees, pretrial detainees, minors, adults, or incarcerated inmates, since it incorporates both the protections of the professional judgment standard and the adversarial proceeding requirements of *Vitek v. Jones*, *supra*.¹¹

The result of the Washington Supreme Court decision runs counter to *Parham*, *Youngberg*, and *Turner*. Rather

¹¹It may well be that the procedural protections of *Vitek* are indeed not necessary prior to actual medication decisions. Note that the *Vitek* Court’s procedural protections were found to be necessary only prior to the transfer to a mental institution. The *Vitek* Court did not intimate that a similar adversarial proceeding needed to be conducted prior to every decision to medicate. Petitioners assert that the professional judgment standard, properly applied, prior to a medication decision, sufficiently protects the rights of incarcerated felons in a state prison, if not all the groups mentioned above.

than assuring the exercise of professional judgment, the Washington court has replaced it — the ultimate decision to medicate is made not by a doctor but by a judge.

Moreover, by requiring a full blown adversarial hearing, complete with expert witnesses and legal counsel, the Washington court has transferred the physician-patient relationship into an adversarial one. In addition, by interjecting a judicial hearing process before treatment can commence, the Washington court has guaranteed additional delay between the time the need for professional treatment is recognized and the time it is administered.

Finally, by requiring clear, cogent and convincing evidence of a compelling state interest, the Washington Court has undercut the holding of *Turner* that only a logical connection need be shown between a challenged prison policy and legitimate penological goals.

Policy 600.30 is consistent with the teachings of this Court in *Parham*, *Vitek*, *Youngberg*, and *Turner*. The holdings below flies in the face of those decisions, with the concomitant effect of injecting the judiciary into the unfamiliar role of medical prescriber and prison administrator. The decision below should be reversed and the policy upheld.

II. Mr. Harper does not possess a constitutional right to refuse antipsychotic medication.

In *Mills v. Rogers*, 457 U.S. 291, 300-301, n. 16 (1982), the Court assumed for the purpose of discussion that an involuntarily committed mental patient retains liberty interests protected directly by the Constitution and that those interests were implicated by the involuntary administration of antipsychotic drugs. The question was not definitively answered — instead, the Court remanded the case in consideration of an intervening Massachusetts Supreme Judicial court's intervening decision. *Id.* at 307.

In *Youngberg*, *supra*, the Court recognized that freedom from bodily restraint is at “* * * the core of the liberty protected by the Due Process Clause from arbitrary govern-

mental action’ which survives criminal conviction and incarceration.” *Youngberg*, 497 U.S. at 317 (citation omitted).

The bodily restraints at issue in *Youngberg* were “soft restraints”. *Id.* at 311, n. 4. However, the *Youngberg* Court found that this restriction on Romeo’s liberty was constitutional if based on the exercise of professional judgment. “[T]he Constitution only requires that the courts make certain that professional judgment in fact was exercised.” *Id.* at 322, (quoting C.J. Seitz, *Romeo v. Youngberg*, 644 F.2d 147, 178 (1980)).

Petitioners assert that the refusal of antipsychotic medication is not a constitutionally protected liberty interest equivalent to the freedom from bodily restraints found in *Youngberg* to be constitutionally protected.

In *Youngberg*, the Court referred to *Greenholtz*, *supra*, regarding the liberty interest protected by the Due Process Clause. The restraint at issue in *Greenholtz* was the legal restraint at stake when a state makes a parole decision. Thus the right to freedom from restraint found in *Youngberg*, was based on the distinction between liberty behind prison walls versus the liberty of a parolee. *Greenholtz*, at 8.

There is an important distinction between complete freedom from restraint as in *Greenholtz* and freedom from physical restraints, as in *Youngberg*. Obviously, there is a greater liberty interest inherent in complete freedom from restraint than the liberty interest at issue when a properly committed individual is treated in a state institution, as was the case in *Youngberg*. This distinction should be kept in mind if the liberty interest discussed in *Youngberg* is utilized as a springboard to find a constitutionally protected liberty interest in freedom from antipsychotic medication.

There is also a significant distinction between the physical restraints involved in *Youngberg* and the administration of medically prescribed antipsychotic drugs. Physical restraints represent a loss of liberty virtually without direct benefit to the individual who is restrained. Rather, physical restraints are merely utilized to protect individuals from themselves (and perhaps to protect others), not as a form of treatment. *Youngberg*, at 311. In contrast, antipsychotic

medication not only serves to protect the individual treated and perhaps others, it also serves to relieve and treat the individual's mental disease or disorder.

In view of these differences, the holding in *Youngberg* should not be read as finding a constitutionally protected liberty interest in refusing antipsychotic medications. *Mills* and *Youngberg* are the only cases in which this Court has addressed a claim of right like that asserted by Harper in this case.¹² In neither case did this Court rule that such a right existed, and none should be found here.

III. The decision of the Washington Supreme Court is not based on a sound medical foundation, provides little, if any real benefit to inmates, and improperly interferes with legitimate state interests.

A. The Washington Supreme Court's decision below rests on a flawed understanding of current medical knowledge.

In its opinion which concluded that procedural due process required a judicial hearing prior to involuntary treatment with antipsychotic medications,¹³ the Washington State Supreme Court conducted a rather selective review of relevant medical literature.

¹²As noted above, the Court remanded in light of *Youngberg*, a case raising a claim by a person civilly committed to be free from involuntary medication. *Rennie v. Klein*, 458 U.S. 1119 (1982).

¹³Regarding the definition of antipsychotic medications, the Washington State Supreme Court in *Harper v. State*, 110 Wn. 2d 873 (1988) at p. 876, n. 3 stated: "Antipsychotic drugs are also referred to as psychotropic drugs, neuroleptics, and major tranquilizers." Pet. A-4, n. 3. While literature in the field frequently uses terms such as antipsychotic, psychotropic, neuroleptic, and major tranquilizer interchangeably, the result of such interchangeability may be confusion. In fact, the terms major tranquilizer, neuroleptic and antipsychotic are synonymous, however, they are a subset of those medications called psychotropics. Psychotropics are any medication which causes effects on a person's mental or emotional state. See Schatzberg & Cole, *Manual of Clinical Pharmacology*, at 24 (1986). The classes of psychotropic medications include anti-depressant drugs; antipsychotic drugs; anti-anxiety drugs; stimulants; lithium carbonate; anti-seizure drugs; and hypnotics. *Id.* It is not disputed that the medications used

Without discussion, the *Harper* court conceded that the benefits of antipsychotic drug treatment are well documented. Indeed, the benefits of antipsychotic medications are widely accepted in the medical community, both for short and long-term treatment. See Kane, *Treatment of Schizophrenia*, 13 *Schizophrenia Bulletin*, at 133-134, 142-143 (1987).

The *Harper* court focused on the possible adverse side effects of such treatment.¹⁴ Pet. A-5. Regarding tardive dyskinesia, a side-effect Mr. Harper did not have, the *Harper* court characterized the condition as "[s]evere and potentially permanent. * * * an irreversible neurological disorder * *

to treat Mr. Harper were antipsychotic drugs, as he suffered from schizophrenia, for which antipsychotic drugs are the generally accepted treatment. See Ban, Guy & Wilson, *Research Methodology and the Pharmacotherapy of the Chronic Schizophrenias*, 22 *Psychopharmacology Bulletin* No. 1, 36 (1986). In fact, pharmacotherapy with neuroleptics is the nearly universal treatment for chronically hospitalized schizophrenic patients. A recent survey indicates over 96 percent were treated with one or more neuroleptics. *Id.*

¹⁴The trial court found that the medications administered to Mr. Harper:

* * * have similar potential neurological side effects, which may be broadly classified as dystonia, akathisia and tardive dyskinesia. Dystonia is an involuntary spasm of the upper body, tongue, throat, or eyes. It is an acute, severe, intense and undesired reaction to antipsychotic medications. It is easily treated with the side-effect medication Cogentin, and may be rapidly reversed within a few minutes. Akathisia is not so dramatic and is usually manifested by an uncontrollable fidget. It is reversible by reduction of the dosage of antipsychotic medication. Tardive dyskinesia is a hidden side effect of antipsychotic medications, which may manifest itself years after treatment in the form of involuntary movements of the mouth, lips, and tongue.

Finding of Fact 9, Pet. B-7, 8.

The trial court also found that Mr. Harper:

* * * complained of and may have exhibited symptoms of acute dystonic reaction and akathisia. He did not exhibit symptoms of tardive dyskinesia. Dr. Petrich did believe that plaintiff suffered dystonia and akathisia but was sometimes skeptical of plaintiff's complaints of side-effects and felt they might be feigned.

Finding of Fact 10, Pet. B-8.

Mr. Harper's symptoms of dystonia and akathisia were treated with Cogentin, a side-effect medication. Pet. A-5, n.4.

*". *Harper*, Pet. A-5. This characterization is incomplete and misleading.

Recent clinical literature indicates that tardive dyskinesia is not irreversible. See generally, *Tardive Dyskinesia and Neuroleptics: From Dogma to Reason*, at 76-91 (D. Casey and G. Gardos ed. 1986); Psychopharmacology, *The Third Generation of Progress*, at 1411-1419 (H. Meltzer ed. 1987).

Further, recent studies indicate that extended low to moderate dosages of antipsychotic medication often results in a stable or improved course of tardive dyskinesia. See Casey, Poulsen, Merdahl, & Gerlach, *Neuroleptic-Induced Tardive Dyskinesia and Parkinsonism: Changes During Several Years of Continuing Treatment*, 22 Psychopharmacology Bulletin No. 1, 250 (1986); Richardson & Casey, *Tardive Dyskinesia Status: Stability or Change*, 24 Psychopharmacotherapy Bulletin No. 3, 471 (1988).

The *Harper* court found a fundamental liberty interest in refusing antipsychotic drug treatment based upon the conclusion that antipsychotic drug treatment is as intrusive as electroconvulsive therapy. Pet. A-6. The *Harper* court came to this conclusion despite the fact that there was no record before it of the comparable benefits and negative side-effects of electroconvulsive therapy and antipsychotic medication. The *Harper* court relied on its own prior decision in *In re Schuoler*, 106 Wn.2d 500, 723 P.2d 1103 (1986) (electroconvulsive therapy in a civil commitment setting).

The *Schuoler* opinion contains no discussion of the benefits of electroconvulsive therapy, nor any discussion of what types of patients are appropriate candidates for electroconvulsive therapy.

Similarly, the *Harper* court did not examine the consequences of its decision which requires a judicial hearing at which the state must show a "compelling state interest" prior to the administration of antipsychotic medication.

By creating a substantial impediment to the use of antipsychotic medication, the *Harper* court indicated its apparent preference for the use of physical restraints, an outmoded practice (in most cases), in light of modern medication. One

result of the *Harper* decision has been an increased use of physical restraints.¹⁵

The *Harper* court also did not consider the medical consequences of the increased use of seclusion as a consequence of its decision. The increased use of seclusion has been found to be a consequence of the right to refuse medications. See generally, *The Right to Refuse Treatment*, (J. Parry ed. 1986).

The *Harper* court's rationale in concluding that Mr. Harper retained a right to refuse antipsychotic medication, despite his mental illness, necessarily places a very high value on Mr. Harper's stated wishes and assumes that his statements regarding refusal were accurate reflections of his true intent. This focus on the protection of Mr. Harper's rights is based on the premise that he was necessarily asserting his rights when he refused antipsychotic medication. However, clinical psychiatric literature indicates " * * * that medication refusal by psychotic inpatients is inextricably linked to the process of illness. * * *" Schwartz, Vingiano & Perez, *Autonomy and The Right to Refuse Treatment: Patients' Attitudes After Involuntary Medication*, 39 Hospital and Community Psychiatry, No. 10, 1049, 1054 (1988).

The *Harper* court's placement of the highest value on Mr. Harper's stated wishes is based on the assumption that his statements were an accurate reflection of his true intent. However, a psychiatric clinical approach focuses on an individual's actual intent or meaning, which may well be different from what he says at any given point in time. *Id.* at 1049.

¹⁵The *Harper* decision also applies to civil committees. Pet. p. 6 n.6. In the first study of the consequences of the *Harper* decision, a marked increase in the use of physical restraint has been found. Not only were the medication refusers restrained more often, but there appears to be a "ripple effect" which was revealed by an increased use of physical restraint upon individuals who were not medication refusers. P. Davidson & D. McBride, *Medication Refusal and Physical Restraint*, Presented to Annual Meeting of the American Psychiatric Association, (May 8, 1989) (available from the American Psychiatric Association, 1400 K Street, Washington, D.C. 20005) (an analysis of the use of physical restraint after *Harper* at the Washington Western State Hospital civil commitment facility).

In the study conducted by Schwartz, et al., *supra*, more than two out of three involuntarily medicated patients who had initially refused treatment and had subsequently been treated involuntarily, after their treatment, believed that the medication was necessary and important for their treatment. *Id.* This result indicates that for most patients, refusing psychotropic medication reflects the patient's illness rather than autonomous functioning or consistent beliefs regarding mental illness or its treatment.

The Schwartz study is consistent with others which have found that factors other than a principled stand for individual autonomy — including anger, whim and psychotic reasoning — underlie most treatment refusals. Applebaum & Gutheil, *Rotting With their Rights On: Constitutional Theory and Clinical Reality in Drug Refusal by Psychiatric Patients*, 7 Bulletin of the American Academy of Psychiatry and the Law 306-315 (1979); Applebaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 American Journal of Psychiatry 340-346 (1980).

In sum, the medical predicate relied upon by the *Harper* court regarding its analysis of antipsychotic medication was meager at best. Further, antipsychotic medication was found comparable to electro-convulsive therapy absent any record before the court. The existence of a fundamental constitutional right and the procedure by which it is protected should not be premised on such an insubstantial medical foundation.

The superficial treatment of the medical implications of the use of antipsychotic medications by the *Harper* court illustrates why treatment refusal is properly a psychotherapeutic and medical issue best addressed by qualified medical professionals exercising professional judgment. The availability of subsequent post-treatment judicial review in conjunction with such professional judgment adequately protects the mentally ill.

B. The decision below impermissibly burdens state prison administrators.

This case presents the question of the standard to be utilized to evaluate the procedural process which protects

any underlying substantive right in the prison context. This is particularly important in light of this Court's recent decision in *Turner v. Safley*, *supra*, in which the Court analyzed decisions involving inmates' rights and concluded that the proper standard of scrutiny for a prison regulation that burdens fundamental rights is "whether * * * [the] regulation that burdens fundamental rights is 'reasonably related to legitimate penological objectives' or whether it represents an 'exaggerated response' to those concerns." *Id.* at 2260-2261.

The *Turner* Court set forth four factors which are relevant to the determination of the reasonableness of a regulation at issue:

1. A valid rational connection between the prison regulation and the legitimate governmental interest which justifies it;
2. Whether there are alternative means of exercising the rights that remain open to prison inmates;
3. The impact that accommodation of an asserted constitutional right will have on correctional officers and other inmates and the allocation of prison resources generally;
4. The availability of effective alternatives as evidence of the reasonableness of a prison regulation. *Turner* at 2262.

The *Turner* Court then applied the "reasonably related" standard of review by utilizing the factors discussed above.¹⁶

In the companion case of *O'Lone v. Estate of Shabazz*, ___ U.S. ___, 107 S. Ct. 2400 (1987), the Court reiterated its approval of the *Turner* analysis and found that it is improper to create a burden on prison officials to prove that no reasonable method exists by which prisoners' rights can be accom-

¹⁶Utilizing the above four factor analysis, the *Turner* Court found that an inmate-to-inmate correspondence rule which permitted correspondence between immediate family members who were inmates at different institutions and permits correspondence between inmates regarding legal matters, but allowed other inmate correspondence only if it was in the best interest of the parties, was reasonably related to legitimate penological interests. *Turner* at 2263-2264.

By applying the above standard of review and relevant factors, the *Turner* Court also found that an inmate marriage regulation which prohibited inmates from marrying other inmates unless the prison Superintendent approved the marriage only after finding a compelling reason, was not reasonably related to a legitimate penological concern. *Id.* at 2263.

modated without creating bonafide security problems. *O'Lone* at 2405.

The application of *Turner* and *O'Lone* to the case at bar clearly indicates that the involuntary medication policy is reasonably related to a legitimate penological interest.

The first *Turner* factor is the requirement of a valid rational connection between the prison regulation and the legitimate governmental interest which justifies the regulation. In the case at bar, the legitimate governmental interest is the protection and treatment of the inmate himself, protection of other inmates, protection of staff, and protection of the public. See Findings of Fact 1, 2(a), 4, 5, 6, and 11, Pet. B-1, 2, 4-6, 11.

The facts of this case illustrate the problem. At all relevant times Harper constituted a likelihood of serious harm to others. Finding of Fact 11, Pet. B-8. Harper's history of violent assaults are documented in the record. Finding of Fact, B-4, 5. Harper's assaultive behavior increases when he does not take medications. *Id.* There can be little doubt that Policy 600.30 — by providing prompt and effective treatment — is rationally connected to legitimate governmental interests.

The second *Turner* factor is whether there are alternative means of exercising the rights that remain open to prison inmates. In unchallenged Findings of Fact, the trial court found that Harper suffered from a mental disorder and as a result, constituted a likelihood of serious harm to others. Finding of Fact 11, Pet. B-8. The trial court also found that the medical treatment provided to Harper by the defendants was consistent with the degree of care, skill, and learning expected of a reasonably prudent psychiatrist. Findings of Fact 12, Pet. B-8.

It is implicit in the trial court's finding of appropriate medical care,¹⁷ that the proper exercise of professional judgment regarding the administration of antipsychotic drugs en-

¹⁷Obviously, a medical decision to treat with antipsychotic medication, whether voluntary or involuntary, will be made after considering the patient's desires, the risk and treatment of adverse side effects, the relative risks and benefits of potential alternatives, and, when appropriate, the opinions of other medical professionals. See *Rennie v. Klein*, *supra*, 720 F.2d at 274 (Seitz, C.J. concurring).

tailed the rejection of treatment without such medication. Clearly the medical professionals found that alternative treatments were not appropriate.

The third factor discussed by the *Turner* Court was the impact that the accommodation of an asserted constitutional right will have on correctional officers and other inmates and the allocation of prison resources generally.¹⁸ It is undeniable that utilization of all of the procedures required by the *Harper* decision below will have a considerable impact on prison resources. Potential costs identified thus far, include the following:

- 1) Fees of counsel appointed to represent indigent inmates;
- 2) Expert witness fees for psychiatric experts to investigate and/or testify on behalf of the indigent inmates;
- 3) Increased legal costs in preparing petitions for involuntary medication and representing staff at hearings;
- 4) Increased time by prison psychiatrists spent preparing for and participating in judicial hearings;
- 5) Increased costs due to the need to provide adequate security by custodial staff at judicial hearings, even if held within the prison.

Additional costs which could be incurred include claims against the state if one or more inmates escape and injures a third party and higher premiums for injury claims by Department employees due to a higher incidence of inmate-staff assaults.

The fourth factor discussed by the *Turner* Court is the availability of effective alternatives as evidence of the reasonableness of a prison regulation.

The availability and effectiveness of a judicial hearing as an alternative to the exercise of professional judgment is the central topic of this case. Petitioners assert that a judicial

¹⁸"When accommodation of an asserted right will have a significant 'ripple effect' on fellow inmates or on prison staff, the courts should be particularly deferential to the informed discretion of correction officials." *Turner* at 2262. The first post-*Harper* study, conducted in a civil commitment setting, indicates a "ripple effect," resulting in increased use of physical restraint. See *supra*, p. 23 n.15.

hearing is not readily available in a large number of cases, nor is such hearing effective, either in terms of protecting and treating the individual inmate, nor the prison community as a whole. Further, petitioners believe that the arguments contained herein show that the overall public interest is not properly served by requiring such a judicial hearing.

The record in this case demonstrates that Policy 600.30 satisfies the four prongs of the *Turner* test. The decision below, on the other hand, requires more than is reasonable under *Turner*, thus frustrating the policy considerations underpinning the *Turner* analysis.

Under the decision below, the judiciary is inextricably entwined in decisions affecting the operation of the Special Offender Center. Only by reversing that decision below, can the Court achieve the goal of limiting judicial involvement in making " * * * the difficult judgments concerning institutional operations." *Turner* at 2261, (quoting *Jones v. North Carolina Prisoners' Union*, 433 U.S. 128, (1977)).

C. By injecting the judiciary into what are essentially medical decisions, the Washington Supreme Court has tilted the balance against legitimate governmental interests.

The level of due process appropriate to protect any substantive constitutional right Mr. Harper may possess must balance the rights of the individual against relevant governmental interests furthered by such treatment.

The state's *parens patriae* interest justifies alleviating suffering by providing effective treatment and extends to the prevention of further mental deterioration. "The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of [mental] disorders to care for themselves * * *." *Addington*, 441 U.S. at 427. The *parens patriae* interests discussed in *Addington* and applied to the civil commitment setting are equally applicable in a prison setting. Mentally disordered inmates incarcerated in our prison systems deserve to receive mental treatments comparable with those provided in the civil commitment setting. Indeed, the Eighth Amendment may man-

date such treatment. See *Estelle v. Gamble*, and *Bowring v. Godwin*, *supra*.

Unchallenged Findings of Fact show that "[a]t all times relevant to this action, [Harper] suffered from a mental disorder * * *" Finding of Fact 11, Pet. B-8 (emphasis added). The record below also indicates that Mr. Harper's condition deteriorated when he discontinued his medications. Finding of Fact 6c, Pet. B-6.

The state's *parens patriae* interest in providing Mr. Harper with necessary mental health care is unreasonably compromised where the approval process for treatment is too onerous, contentious or delayed.¹⁹ *Parham*, 442 U.S. at 606.

Mr. Harper's history of assaultive behavior requires that the state exercise its police power to appropriately medicate him for the protection of others. "[T]he state also has authority under its police powers to protect the [relevant] community from the dangerous tendencies of some who are mentally ill." *Addington* at 427. At all relevant times, Mr. Harper suffered from a mental disorder and as a result constituted a likelihood of serious harm to others. Finding of Fact 11, Pet. B-8. Mr. Harper's history includes incidents of assaultive behavior attributable to his mental disease. These assaultive incidents increased when he did not take prescribed medications. Findings of Fact 5, Pet. B-5.

Mr. Harper's assaultive behavior is a threat to other inmates, prison staff, and himself. The need to medicate Mr. Harper is a necessary and proper exercise of state police power to protect others in the prison community.

This court has previously recognized the significant state interest in reserving costly mental health facilities for those with the greatest need. *Parham*, 442 U.S. at 605-606. There is a concurrent state interest in " * * * allocating priority to the diagnosis and treatment of patients as soon as they are admitted rather than to time-consuming procedural minuetts before [treatment]." *Parham* at 606. As the *Parham* Court noted:

¹⁹The need for scheduling the hearing and time for preparations by counsel, makes delay inevitable if a judicial hearing is required. See *Parham* at 606-607.

One factor that must be considered is the utilization of the time of psychiatrists, psychologists, and other behavioral specialists in preparing for and participating in hearings rather than performing the task for which their special training has fitted them. Behavioral experts in courtrooms and hearings are of little help to patients.

Id. at 606-607.

The state's interest in helping those inmates who most need the psychiatric diagnosis and treatment provided at the Special Offender Center, is inhibited under the decision below because of time-consuming procedural requirements prior to initiating treatment. The transfer of prisoners to other ordinary prison communities is delayed when treatment is withheld for any period of time, no matter how short.

The state's authority to seek to administer medically prescribed treatment is analogous to the situation presented in *Parham, supra*. In *Parham*, the Court reviewed the commitment procedures of juveniles who were wards of the state or whose commitments were requested by their natural parents. The *Parham* Court found the two situations did not require different procedural protections. *Parham* at 618-619.

The *Parham* Court reasoned that given the extensive records upon which medical judgments were made, as well as the good faith of the medical profession, the state agency could constitutionally speak for the child. *Id.* at 620. If the state, acting for a ward, can constitutionally make such an admission decision — a decision of tremendous consequence to that child's acknowledged liberty interest — certainly it is appropriate to allow the state, acting for a felon, to make the treatment decision at issue in this case.

There can be no doubt that the defendant-petitioners in this case were acting in the best medical interests of Mr. Harper.

At all times relevant to this action, the medical treatment provided to plaintiff by defendants, including the administration of antipsychotic medications, was consistent with the degree of care, skill, and learning expected of a reasonable prudent psychiatrist in the State of Washington, acting in the same or similar circumstances.

Finding of Fact 12, Pet. B-8.

The state's police power interests extend to the general community upon Mr. Harper's release from prison. Untreated, Mr. Harper poses a substantial risk to the community upon release. Obviously if he is not treated during his incarceration, there is an increased chance of his being mentally unprepared to deal with society at large. The state has an interest in raising his level of functioning and treating him with the best means available so that he may have the greatest opportunity to function as a contributing member of society. Given Mr. Harper's history of civil commitment, criminal incarceration, and dangerous tendencies, his mental condition when he is ultimately released is indeed a proper state concern.

The state also has an important interest in limiting judicial intervention in medical decisions made in state institutions, thus, minimizing " * * * interference by the federal judiciary with the internal operations of these institutions." *Youngberg v. Romeo*, 457 U.S. at 323.

The judicial hearing required by the *Harper* court has changed the role of the judiciary. If a judicial hearing is required prior to the administration of antipsychotic medication, the court will become:

* * * baseline providers of procedural due process, collapsing their normal review function into this threshold function. With this would go all the cumbersomeness, expense, and delay instant to judicial proceedings every time an involuntary medication decision had to be made for any inmate. * * * District [court] judges would thereby be cast in the role of making the primary decisions on purely medical and psychiatric questions, rather than reviewers of such decisions made by qualified professionals.

U.S. v. Charters, 863 F.2d 302, 309 (4th Cir. 1988).

Against the state interests discussed above, this Court must weigh Mr. Harper's interests. The interest focused on by the Washington State Supreme Court below, was his claimed liberty interest in refusing antipsychotic drug treatment. However, as discussed *supra* at p. 23-24, the protection of this freedom is based on the assumption that his statements regarding refusal were accurate reflections of his true

intent. This assumption is not borne out by clinical research. Rather, medication refusal is very often inextricably linked to the process of illness. *Id.*

The other major concern of the *Harper* court below, was the possibility of side effects associated with the use of the drugs involved. Not only did the Washington State Supreme Court conduct a cursory analysis of medical evidence regarding possible side effects from antipsychotic medications, the *Harper* court did not balance the possibility of those side effects against the effects of seclusion and restraint, likely nonmedicating alternatives, upon Mr. Harper. *See*, discussion regarding restraint and seclusion *supra* at 22-23. Nor did the Washington court consider the lower level at which Mr. Harper would function without the medication.

A proper balancing of legitimate state interests identified above and the interests of Mr. Harper, particularly when due process protections including an adversarial hearing and the exercise of professional judgment are considered, mandate the conclusion that Mr. Harper's interests were appropriately protected by Policy 600.30 in the instant case.

CONCLUSION

Special Offender Center Policy 600.30 combines the utilization of "professional judgment" in the context of an adversarial *Vitek*-type hearing prior to involuntary treatment. It clearly meets the standards established by this Court in *Youngberg*, *Vitek*, and *Parham*. Read together in a common sense fashion, there can be no doubt but that the combination of the exercise of professional judgment and an adversarial hearing conducted prior to medication decisions adequately protects the interest of an incarcerated inmate.

As applied, the Special Offender Center involuntary medication policy meets constitutional muster. The decision of the Washington Supreme Court should be reversed, with direction to reinstate the decision of the trial court.

DATED this 10th day of May, 1989.

Respectfully submitted,

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RESPONDENT'S

BRIEF

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CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Fourth Amendment to the United States Constitution. The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated, and no warrants shall issue, but upon probable cause, supported by oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.

Fourteenth Amendment to the United States Constitution, sec. 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

STATEMENT OF THE CASE

In 1976, the plaintiff was found guilty of the crime of robbery and sentenced to prison. There was no insanity finding; no issue was raised as to competency. *See* Finding of Fact 4, Petition for Writ of Certiorari to the Washington Supreme Court, Appendix (hereinafter Pet.) B-4. He was incarcerated from 1976 to 1980 during which time he was held at the Washington State Penitentiary where, at various times, he was housed in the mental health unit and was treated voluntarily with antipsychotic medication. *Id.* Plaintiff was paroled in 1980 with the condition that he participate in psychiatric treatment. *Id.* His parole was revoked in December of 1981, after he assaulted two nurses at Cabrini Hospital, Seattle. *Id.*

Following his return to prison, plaintiff was sent to the Special Offender Center (hereinafter SOC) in January 1982. Finding of Fact 5, Pet. B-4. No judicial hearing was held prior to this transfer; the transfer was accomplished at the direction

of the Washington State Department of Corrections. *Id.* at B-4, 5.

SOC is a one hundred and forty-four bed correctional institution administered by the Department of Corrections pursuant to Wash. Rev. Code sec. 72.65.010. Finding of Fact 2, Pet. B-2. At the time the Findings of Fact and Conclusions of Law were entered, May 12, 1987, of the one hundred and forty-four inmates then housed at SOC, approximately twenty-seven were being involuntarily medicated pursuant to the SOC policy. *Id.*

Plaintiff voluntarily participated in treatment at SOC, including administration of antipsychotic medications from January to February 1982 and May to November, 1982, when he began refusing his medication. Finding of Fact 5, Pet. B-5. Plaintiff has been variously diagnosed by psychiatrists at SOC as suffering from manic depression, schizo-affective disorder, or schizophrenia. *Id.* Plaintiff's history includes incidents of assaultive behavior, which his doctors attribute to his mental disease and which they believe increased when he did not take his medications. *Id.*

At the time Harper was incarcerated at SOC, the rules regarding the involuntary administration of antipsychotic medications permitted such when a prisoner suffered from a mental disorder which rendered him gravely disabled or dangerous to self or others. Finding of Fact 3, Pet. B-3. There was no requirement of a finding that the medication was appropriate to or benefitted the prisoner. *Id.* There was no requirement that the prisoner be incompetent to make his own treatment decisions. *Id.*

The rules in force in 1982, when defendants began to medicate Harper, provided that a prisoner would be given 24 hours to prepare for an involuntary medication hearing. *Id.* He was entitled to the assistance of a lay adviser from the Department of Corrections, but could not have an attorney. *Id.*, Finding of Fact 7, Pet. B-6. The reviewing panel was composed of a prison psychiatrist and a prison psychologist, either of whom may

have treated the prisoner in the past, and the associate superintendent of SOC. Finding of Facts 3, 6 and 7, Pet. B-3, 5, 7. Before the hearing, the panel met with the treating staff outside the presence of the prisoner to determine "what the position of the staff would be at the hearing. SOC staff members would summarize their positions for the hearing committee" Finding of Fact 7, Pet. B-6. After this was finished, the prisoner was brought into the hearing. *Id.* The rules of evidence were not followed. Pet. A-7. The only review of the panel's decision was by the SOC superintendent. Pet. A-6.

On November 23, 1982, SOC had a panel meeting regarding Harper's refusal of treatment. Finding of Fact 6, Pet. B-5. The treating physician requesting involuntary medication was Dr. John Petrich. *Id.* The panel authorized involuntary medication and the superintendent upheld its decision. *Id.* Fifteen days later, Harper's continuing involuntary medication was approved by a panel which included Dr. Petrich, who was not the treating physician at that time. *Id.* Harper continued to be involuntarily administered medication for the following three and half years, except for one month when he was transferred briefly to the Washington State Reformatory. Finding of Fact 6, Pet. B 5-6.¹ He received the required hearings and reviews during this time. *Id.*

Harper filed this lawsuit for injunctive relief and damages in February 1985. Joint App. 1. Prior to trial, Harper was transferred to Walla Walla State Prison, where his request to be free of antipsychotic medication was respected. Finding of Fact 8, Pet. B-7. The trial in this case was held on March 9-10, 1987. *Id.*² By the time of the trial, he had received no antipsychotic

¹ Mr. Harper was treated with a wide variety of anti-psychotic medication including Trialafon, Haldol, Prolixin, Taractan, Loxitane, Mellaril, and Navane. Finding of Fact 9, Pet. B-7; See Parts II and III B.

² Although Harper sought an order to transport him from Walla Walla to the trial, the trial court denied his motion, and Harper was not allowed to be present at the hearing in this case or to testify in his own behalf. Finding of Fact 1, Pet. B-2.

medication for almost one year. Finding of Fact 8, Pet. B-7.

On May 12, 1987, the trial court found that Harper had a right to refuse treatment, but that the SOC procedures sufficiently protected this right. Harper appealed to the Washington Supreme Court, which found on July 7, 1988, that Harper had a protected liberty interest in refusing antipsychotic drug treatment and that the SOC procedures were inadequate to protect that interest. The court further found that Harper was not entitled to money damages because the constitutional right violated was not clearly established at the time of the conduct. The court remanded for consideration of Harper's state law claims and his claims for declaratory and injunctive relief.

SUMMARY OF ARGUMENT

This case is moot and should be dismissed. Harper has not been at SOC nor has he been medicated since the summer of 1986. In addition, the state of Washington recently enacted legislation that would grant judicial hearings to a class of persons who are not distinguishable from SOC residents.

Walter Harper's incarceration is the result of a criminal conviction. It is not the result of an adjudication of incompetency or a finding of insanity. The sentencing court did not find that Mr. Harper was gravely disabled or a harm to himself or others.

Mr. Harper asserts that he has a privacy interest in not being involuntarily administered antipsychotic medications and that that interest cannot be infringed absent a judicial hearing with its attendant procedural protections, including the right to counsel.

Mr. Harper's liberty interest is both state-created and derives from the federal Constitution. The federal constitutional interest involves two separate aspects of the right to privacy: first, the privacy right under the Fourth and Fourteenth Amendments which protects a prisoner from being

forced to submit involuntarily to intrusive medical or surgical operations; second, the Fourteenth Amendment privacy right which precludes the state from substituting its own decision regarding medical treatment for that of a competent individual, even if the treatment may be beneficial.

In *Mathews v. Eldridge*, 424 U.S. 319, at 335 (1976), the Court enunciated a balancing test to determine what procedural protections are required before a state may infringe a protected liberty interest. A close analysis of the factors in *Mathews* compels the conclusion that a judicial hearing is required before the state may overcome a patient's interest in being free of antipsychotic medications.

First, Harper's private interest is of the most compelling nature. Psychotropic medications of the kind administered to Walter Harper have serious and potentially irreversible side effects. A significant number of patients are not benefited by these drugs. This is particularly true of mentally disordered offenders in prison settings, which are not conducive to psychiatric treatment. Even in psychiatric settings, the efficacy of these drugs is uncertain.

Second, the risk of an erroneous deprivation of the interest, where the decision to forcibly medicate is made within the prison walls, is great. With scarce resources, prisons must control the behavior of those from our society who are most dangerous. Prisons and prison officials are institutionally biased toward control of inmates and all too often medicate for this reason rather than for treatment purposes.

The prison procedures governing the involuntary administration of antipsychotic drugs are not clearly articulated. For example, Mr. Harper was excluded from that portion of the "hearing" where prison staff explain to the decision-makers why treatment is necessary; the standards governing whom to medicate are so broad as to inevitably lead to error.

Third, the probable value of judicial hearings in reducing the risk of erroneous deprivation is great. The decision to accept or

refuse medical treatment is one which is based upon a patient's personal values and is not limited to medical advisability. For example, psychiatric patients have refused medication for religious reasons, or, as here, because the negative side effects outweighed the benefits of the drugs. The state's interest in providing a competent individual with unwanted medical treatment for a non-contagious, non-life-threatening condition does not supersede that individual's right to make his or her own medical decisions, except in emergencies, not present here, which create a serious physical threat to the individual or to others around him.

A court, as opposed to a prison, is institutionally capable of (and practiced in) considering these personal values. Similarly, courts decide questions of the competency of individuals.

The common law has always reserved the right to make treatment decisions to an individual, even if the individual makes what, for another, might be a medically unwise choice. Competency is a legal question, not a medical one. Allowing the decision to forcibly medicate to be made by prison officials would eliminate the requirement of informed consent for competent individuals to accept medical treatment.

Fourth, the governmental interest in a calm prison setting or its *parens patriae* authority are not sufficient to overcome Harper's liberty interest. Alternatives to forcible medication which do not implicate the liberty interest at issue here are available to prison authorities to control inmates' behavior: isolation and physical restraints. The long-term use of antipsychotic drugs is not related to the legitimate goal of prison security and safety.

The prison's interest in providing medical care to its inmates cannot, especially where that treatment is as potentially dangerous as antipsychotic medication, override a competent prisoner's right to make his own treatment decisions.

The fiscal and administrative burden is slight and cannot justify doing away with a decision-making process that includes a neutral and detached magistrate.

ARGUMENT

I. The Court Should Dismiss This Case As Moot

Respondent Walter Harper brought this suit for declaratory, injunctive and monetary relief in February 1985. Harper was transferred to Walla Walla State Prison in either June or July 1986, where he has remained since his transfer.³ The authorities at Walla Walla prison do not follow the SOC procedures on involuntary medication, and Harper has not been subject to these procedures nor involuntarily medicated since that time.⁴ Moreover, should he be returned to SOC in the future, he would not be subject to the procedures used on him in the past because of a change in Washington law. The claim for injunctive relief is therefore moot: there is at present no live controversy between Harper and petitioners. Any remaining live claim for damages for violation of his federal rights was finally determined against Harper when the Washington Supreme Court denied his claim and he did not seek review of that decision in this Court.

This case does not fall under the exception to mootness for cases which are capable of repetition yet evade review. These cases generally involve situation when "the challenged action was in its duration too short to be fully litigated prior to its cessation or expiration, and (2) there was a reasonable expectation that the same complaining party would be subjected to the same action again." *Weinstein v. Bradford*, 423 U.S. 147, at 149 (1974); *Murphy v. Hunt*, 455 U.S. 478, at 482 (1982). In this case, the challenged action—Harper's involuntary medication without a judicial hearing—began in November of 1982 and

³ See decision of trial court; Finding of Fact 6-d, Pet. B-6 is to the effect that Harper was transferred to Walla Walla in June 1986. Finding of Fact 8, Pet. B-7 lists the transfer date as July 1986.

⁴ Finding of Fact 8, Pet. B-7. According to the Washington Supreme Court, Harper was not involuntarily medicated after June 1985. Pet. A-3.

continued until either June 1985 or June 1986.⁵ This three or four-year time period is surely enough time to litigate the issue and far more than has ever been found to impede full litigation by a court. *Roe v. Wade*, 410 U.S. 113 (1973) (nine months); *United States v. New York Telephone Co.* 434 U.S. 159, at 165 (1977) (surveillance of phones authorized for up to 40 days); *Globe Newspaper Co. v. Superior Court*, 457 U.S. 596 (1982) (duration of a criminal trial).

Nor is there a reasonable expectation that Harper will be subjected to the SOC procedures again. In the first place, if Harper should reexperience difficulties with mental illness, he does not necessarily face inevitable transfer to SOC. There are several alternatives available to the state besides a transfer to SOC. He could be treated at Walla Walla, as he was between 1976 and 1980; he could be transferred to a state hospital under Washington statute;⁶ or he could be transferred to SOC. If he were transferred to SOC, he would have to be prescribed psychotropic medication and refuse it; Harper in the past has both accepted and refused medication and it is difficult to predict what his future actions would be. In addition, the State of Washington recently enacted legislation requiring judicial hearings prior to the involuntary administration of antipsychotic drugs to civilly committed patients.⁷ This class of persons is not distinguishable, in this context, from prison inmates and therefore equal protection would require that hearings be provided for Harper and all those in his class.

⁵ There is some confusion in the record as to when Harper ceased being medicated involuntarily. The Washington Supreme Court noted that "between November 1982 and June 1985, Harper was involuntarily medicated with a variety of drugs." Pet. A-3. The trial court, on the other hand, found that "continuing until June 1986, when he was transferred to the Washington State Penitentiary, antipsychotic medications were administered to plaintiff under SOC 600.30." Pet. B-6.

⁶ Wash. Rev. Code sec. 72.68.031.

⁷ 1989 Wash. Laws ch.120, sec. 8.

Harper's claims under the federal Constitution are moot, and are not "capable of repetition yet evading review."

II. Respondent Harper Has A Protected Liberty Interest To Be Free From The Forced Administration Of Antipsychotic Drugs

Walter Harper has both a state-created interest and a federal constitutional right in not being forcibly injected with psychotropic medication. The federal constitutional interest involves two separate aspects of the right to privacy. The first is the privacy right under the Fourth and Fourteenth Amendments which protect a prisoner from being forced to submit involuntarily to intrusive medical or surgical operations solely for the penological purpose of maintaining an orderly prison. The second is the Fourteenth Amendment privacy right which precludes a state from substituting its decision regarding medical treatment for that of a competent person, even if that treatment may be beneficial.

The security of one's person from state control is "[a]mong the historic liberties"⁸ which has been recognized for centuries as part of the private sphere of individual liberties.⁹ The right of a competent adult to refuse medical treatment is well established in common law.¹⁰ It is a "fundamental principle that

⁸ *Ingraham v. Wright*, 430 U.S. 651, at 673 (1977).

⁹ "The absolute rights of every Englishman which, taken in a political and extensive sense, are usually called their liberties . . . [and] may be reduced to three principal or primary articles; the right of personal security, the right of personal liberty, and the right of private property The right of personal security consists in a person's legal and uninterrupted enjoyment of his life, his limbs, his body, his health, and his reputation." St. George Tucker, ed., *Blackstone's Commentaries*, Vol II (Philadelphia 1803), reprinted Augustus Kelley, New York 1969, pp. 127, 129.

¹⁰ *Mills v. Rogers*, 457 U.S. 291, at 294 n. 4 (1982).

'[e]very human being of adult years and sound mind has a right to determine what shall be done with his body.'"¹¹

This Court need not decide whether Respondent has a liberty interest to refuse antipsychotic medications which derives from the Constitution. "State-created liberty interests are entitled to the protection of the federal Due Process Clause" *Mills v. Rogers*, 457 U.S. 291, at 300 (1982). When a state creates a liberty interest, "due process protections are necessary 'to ensure that the state-created right is not arbitrarily abrogated.'" *Vitek v. Jones*, 445 U.S. 480, at 489 (1980) quoting *Wolff v. McDonnell*, 418 U.S. 539, at 557 (1974).

Washington State does recognize a state-created liberty interest in refusing antipsychotic medication. That interest, in *Harper*, was held to derive from the common law and the constitutional right to privacy. The court below made specific reference to the common law principle that "competent adults have a right to determine what shall be done to their bodies." Pet. A-4 citing, *inter alia*, *In re Schuoler*, 723 P.2d 1103, at 1107 (Wash. 1986) ("This right is grounded in both common law and constitutional principles.").¹² This state-created liberty inter-

¹¹ See *Smith v. Shannon*, 666 P.2d 351, at 354 (Wash. 1983), quoting *Schloenderff v. Society of N.Y. Hosp.*, 105 N.E. 92 (N.Y. 1914) (Cardozo, J.); *Harper v. State*, Pet. A-4. See generally Keeton, *Prosser and Keeton on the Law of Torts*, sec. 18, at 116-119 (5th Ed. Supp. 1984).

¹² The other cases cited in both the *Harper* decision, Pet. A-4, and in *In re Schuoler*, 723 P.2d at 1107, make it abundantly clear that the State of Washington recognizes a state-created liberty interest in refusing antipsychotic drugs. Additionally, the SOC policy recognizes, if it is not an independent source for, this state-created liberty interest.

Subsequent to the *Harper* decision, the Washington State Legislature amended the civil commitment laws to provide: "each person involuntarily detained [or] committed for treatment and evaluation [has the right] not to consent to the administration of antipsychotic medications and not to have antipsychotic medications unless ordered

est is entitled to Due Process Clause protections. *Vitek v. Jones*, *supra*, at 480.

Even if this Court were to find that there is no such state-created liberty interest, such a protected liberty interest is implicit in the Constitution. It derives its force from the Fourth Amendment which "guarantees the privacy, dignity and security of persons against certain arbitrary and invasive acts by officers of the Government or those acting at their direction." *Skinner v. Railway Labor Executives*, 57 U.S.L.W. 4324, at 4327 (1989).¹³

Forcible stomach pumping,¹⁴ "compelled intrusion into the body for blood to be analyzed for alcohol content"¹⁵ and surgery to remove a bullet from a suspect's body¹⁶ are all Fourth Amendment questions raising issues to the right to privacy. The involuntary intramuscular injection of antipsychotic medi-

by a court." 1989 Wash. Laws ch. 120, sec. 8 (Deletions not indicated).

The state-created liberty interest raises equal protection issues which were not addressed by the Washington Supreme Court. Pet. A-4, n. 2. Similarly, Mr. Harper's First Amendment claim was not considered by the court. *Id.* See *Bee v. Greaves*, 744 F.2d 1387, at 1393-94 (10th Cir. 1984), *cert. denied* 469 U.S. 1214 (1985) (finding that forced administration of antipsychotic drugs raises First Amendment concerns. "The First Amendment protects the communication of ideas, which itself implies protection of the capacity to produce ideas."). The freedom and capacity to think and produce ideas is a necessary corollary of free expression. See *Abood v. Detroit Bd. of Education*, 431 U.S. 209, at 230 (1977); *Stanley v. Georgia*, 394 U.S. 557, at 564 (1969).

¹³ The civil nature of the intrusion does not preclude its consideration as a fourth amendment issue; *Skinner v. Railway Labor Executives*, 57 U.S.L.W. 4324, at 4327 (1989) (citing *Camara v. Municipal Court*, 387 U.S. 523, at 528 (1967)).

¹⁴ *Rochin v. California*, 342 U.S. 165 (1952).

¹⁵ *Schmerber v. California*, 384 U.S. 757, at 767 (1966).

¹⁶ *Winston v. Lee*, 470 U.S. 753, at 759-60 (1985).

cations into the body of the Respondent does, as do these other physical intrusions into the body, infringe an expectation of privacy that society recognizes as reasonable. See *Skinner v. Railway Labor Executives*, at 4328.

Although a prisoner has no reasonable expectation of privacy in his cell,¹⁷ prisoners do have a reasonable expectation that the privacy of their bodies and their minds will not be physically invaded by the state. *Winston v. Lee*, 470 U.S. 753, at 759-60; *Bell v. Wolfish*, 441 U.S. at 560 (permitting visual searches of the body cavities but emphasizing "the inmate is not touched . . . at any time"); *Houchins v. KQED Inc.*, 438 U.S. 1, at 5 n.2 (1978) ("Inmates in jail, prisons or mental institutions retain certain fundamental rights of privacy. . . .").

The antipsychotic medications at issue herein are far worse than, for example, the surgery rejected in *Winston v. Lee*, since they are ongoing, are used over years of time and may have severe and permanent consequences; they affect the brain and are used in prison settings principally to control unacceptable or aggressive behavior, rather than for therapy of an individual prisoner.

That the intrusion is involuntary is of particular significance. Where the state "proposes to take control of respondent's body . . . [t]his kind of surgery involves a virtually total divestment of respondent's ordinary control over a surgical probing beneath his body." *Winston v. Lee*, 470 U.S. 753, at 765 (1985). Pumping a stomach can save a person's life; but forced on a person by a state for state purposes, it becomes "too close to the rack and screw to permit of constitutional differentiation."¹⁸

The right to privacy includes the right to make one's own medical decisions. "[F]reedom to care for one's health and

¹⁷ *Hudson v. Palmer*, 468 U.S. 517 (1984).

¹⁸ *Rochin v. California*, 342 U.S. 165, at 172 (1951).

person" is part of the right to privacy. *Doe v. Bolton*, 410 U.S. 179, 213, 219 (1973) (Douglas, J. concurring). The freedom from the unwanted administration of antipsychotic drugs is encompassed within this right to privacy. While this Court has never considered whether the Constitution recognizes such a liberty interest it has "assumed" such a liberty interest.¹⁹

That Respondent is a prisoner does not extinguish his liberty interest to refuse antipsychotic medication. The right to make one's own medical decisions has been found by both federal and state courts to extend to prisoners²⁰ and to pretrial detainees.²¹ It is axiomatic that "convicted prisoners do not forfeit all constitutional protections by reason of their conviction and confinement in prison . . . and that they may claim the protection of the Due Process Clause to prevent additional deprivation of life, liberty or property without due process of law." *Bell v. Wolfish*, 441 U.S. 520, at 545 (1979).

¹⁹ See *Mills v. Rogers*, 457 U.S. 291, at 299 (1982) "[W]e assume for purposes of this discussion that involuntarily committed mental patients do retain liberty interests protected directly by the Constitution [citation omitted] and that these interests are implicated by the involuntary administration of antipsychotic drugs." *Id.* n. 16. Of course, the Respondent is incarcerated pursuant to a criminal conviction; he was not adjudged incompetent or insane. Pet. A-9.

²⁰ *Runnels v. Rosendale*, 499 F.2d 733, at 735 (9th Cir. 1974); *Doe v. Coughlin*, No. 88-CV-964 at 9, 18 (N.D.N.Y. October 12, 1988) ("[T]he value of making independent decisions concerning one's self . . . may be even more essential for a prisoner than a person who enjoys the freedoms associated with life outside of prison, and the personal strength derived from those freedoms that the prisoner be accorded the ability to protect and shape his identity to as great a degree as possible."); *Keyhea v. Rushen*, 223 Cal. Rptr. 746 (Cal. App. 1986); *Large v. Superior Court*, 714 P.2d 399 (Ariz. 1986); *Zant v. Prevatte*, 286 S.E.2d 715 (Ga. 1982); *In re Woodall*, No. A041054, 89 Daily Journal DAR 5192 (Cal. App. April 18, 1989).

²¹ *Bee v. Greaves*, 744 F.2d 1387 (10th Cir. 1984), cert. denied 469 U.S. 1214 (1985).

In *Vitek v. Jones*, 445 U.S. 480 (1980), this Court held there was a protected liberty interest in avoiding transfer from a prison to a mental hospital. "The stigmatizing consequences of a transfer to a mental hospital for involuntary psychiatric treatment, coupled with the subjection of the prisoner to mandatory behavior modification as a treatment for mental illness, constitute the kind of deprivations of liberty that requires procedural protection." *Id.* at 494. *Vitek* principally concerned avoiding the stigma of a label of mental illness. It did not raise privacy issues such as the ones presented here.

There is no privacy right in where a prisoner is physically located, although there may be a liberty right in not being transferred to a mental hospital involuntarily. Not considered in *Vitek* was the possibility of forced treatment with antipsychotic drugs, a far greater intrusion on privacy than behavior modification, which does not touch the body and has no effect on chemicals in the brain. The Court in *Vitek* explicitly noted that if an "ordinary citizen [were] subject to these consequences [stigma and mandatory behavior modification], it is undeniable that protected liberty interests would be unconstitutionally infringed absent compliance with the procedures required by the Due Process Clause. We conclude that a convicted felon also is entitled to the benefit of procedures appropriate in the circumstances before he is found to have a mental disease and transferred to a mental hospital." *Id.* at 492-93. Both the transfer to a mental hospital in *Vitek* and the forcible administration of antipsychotic drugs at issue herein are not "within the range of conditions of confinement to which a prison sentence subjects an individual." *Id.* at 493. As with "ordinary citizens" it is undeniable that Harper has a liberty interest in being free of the unwanted administration of antipsychotic medication.

Furthermore, every federal appellate court (including all those cited by petitioner) that has considered the issue of the right to refuse treatment has agreed that patients and prisoners do retain a constitutionally protected liberty interest in

refusing medication.²² All state supreme courts that have decided the issue have also found that a right to refuse treatment exists.²³ The issue is not so much whether such a liberty interest exists, but rather what circumstances must be present and what procedures must be provided before this right may be overridden by the state.²⁴

III. A Judicial Hearing Is Required To Protect Harper's Interest To Be Free From The Forced Administration Of Antipsychotic Drugs

In cases involving the determination of what procedural due process protections are required before a person's rights may be limited or lost, this Court traditionally engages in the balancing test initially outlined in *Mathews v. Eldridge*, 424 U.S. 319 (1976). Four distinct factors must be weighed: "[1]

²² *E.g. United States v. Charters*, 863 F.2d 302, at 305-06 (4th Cir. 1988) (en banc); *Project Release v. Prevost*, 722 F.2d 960, at 977-79 (2nd Cir. 1983).

²³ See *e.g. Jarvis v. Levine*, 418 N.W.2d 139, at 148-49 (Minn. 1988); *State ex rel Jones v. Gerhardstein*, 416 N.W.2d 883 (Wisc. 1987); *In re Boyd*, 403 A.2d 744, at 748 (D.C. 1979) (refusal for religious reasons); *In re Commitment of M.P.*, 500 N.E.2d 216, at 221 (Ind. 1986); *Opinion of Justices*, 465 A.2d 484, at 489 (N.H. 1983); *Rivers v. Katz*, 495 N.E.2d 337, at 341 (N.Y. 1986); *In re K.K.B.*, 609 P.2d 747, at 749 (Okla. 1980).

²⁴ The question of whether Harper has a right to refuse treatment was raised for the first time in petitioner's brief to this Court. In the petition for certiorari, and in the proceedings below, the state's disagreement with respondent was entirely procedural and concerned whether a judicial hearing was required and what the standard proof should be before a prisoner could be involuntarily medicated, "assuming that an incarcerated felon does possess a constitutionally protected liberty interest in refusing antipsychotic medication." Petition for Certiorari at 10. The United States in its amicus curiae brief concedes that "a prison inmate ordinarily retains a liberty interest in not receiving antipsychotic medication against his will." P. 15.

first, the private interest that will be affected by the official action; [2] second, the risk of an erroneous deprivation of such interest through the procedure's use, and [3] the probable value, if any, of additional or substitute procedural safeguards; and [4] finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail." *Id.* at 335.²⁵

A. Walter Harper Has A Compelling Interest In Being Free From Forced Administration Of Antipsychotic Medication.

It is difficult to imagine an interest of a more compelling nature than forced treatment with antipsychotic medications which, by their very nature, are designed to affect one's thought processes. Mr. Harper's incarceration is not the result of a judicial finding of incompetency or insanity. When he was convicted, he, along with the court, could have had no expectation that forced medication would be a part of the conditions of confinement.

Antipsychotic drugs are used in the treatment of persons suffering from schizophrenia and major affective disorders. An initial problem is that the misdiagnosis rate for schizophrenia may be as high as 40%. This statistic alone suggests that antipsychotic drugs are inappropriately prescribed in many cases.²⁶ Additionally, there is no scientifically sound method to

²⁵ Petitioner's use of the *Turner v. Safley*, 482 U.S. 78 (1987), test to determine the appropriate procedural requirements in this case is inappropriate. The *Turner* standards are used to determine whether a prisoner has a substantive constitutional right, not to outline the procedures necessary to protect that right.

²⁶ Kemna, *Current Status of Institutionalized Mental Health Patients' Right to Refuse Psychotropic Drugs*, 6 J. Legal Med. 107, at 115 (1985). The drugs themselves may mask psychotic symptoms which in turn interfere with continuing diagnosis. Gaughan & LaRue, 4 Law & Psychology Rev. at 55.

determine the most appropriate drug to prescribe.²⁷

Psychotropic medications constitute an extremely serious intrusion on an individual's body and mind. Though widely used, they are very controversial within psychiatry, among patients and for the general public. Their efficacy is disputed; their side effects are not.

The side effects include dystonia, akathisia and tardive dyskinesia. Finding of Fact 9, Pet. B-7. Dystonia is an involuntary spasm of the upper body, tongue, throat, or eyes; it is an acute, severe, intense and undesired reaction to antipsychotic medications. *Id.*

Akathisia begins a few days after initiation of medications, and ranges from "a subjective feeling of muscular discomfort to an agitated, desperate, markedly dysphoric pacing with hand-wringing and weeping."²⁸ It may include "feelings of fright, rage, terror, or sexual torment."²⁹ Akathisia has caused patients to attempt suicide.³⁰ It has also caused "bizarre acts in newly treated psychotic patients [such as] episodes of disrobing, running and trying to climb walls, ceaselessly walking in hallways, going through other patients' possessions and trying to void in a wastebasket."³¹

Tardive dyskinesia is a devastating syndrome. If it is not detected in its early stages, it is usually irreversible.³² The

²⁷ Goodman & Gilman, *The Pharmacological Basis of Therapeutics*, at 172-74 (1975); Hollister, *Clinical Use of Psychotherapeutic Drugs*, at 30-32 (1977).

²⁸ Schatzberg and Cole, *Manual of Clinical Psychopharmacology* 101 (1986).

²⁹ Krupp, Schroeder, et al., *Current Medical Diagnosis and Treatment* 628 (1987).

³⁰ Drake and Ehrlich, *Suicide Attempts Associated with Akathisia*, 142 American Journal of Psychiatry 499 (1985).

³¹ Friedman and Wagner, *Akathisia: the Syndrome of Motor Restlessness*, 35 American Family Physician 146 (1987).

³² Breggin, *Psychiatric Drugs: Hazard to the Brain*, at 90 (1983).

symptoms of tardive dyskinesia include uncontrollable facial grimacing and twitching, trunk twisting, pelvic thrusting, and a variety of toe, ankle and leg movements.³³ The prevalence of tardive dyskinesia is far higher than the 10-20% figure cited by the American Psychiatric Association in their brief. This is because the data they cite regarding the prevalence of tardive dyskinesia was gathered before 1980.³⁴

Since 1980, estimates of prevalence have been rising steadily. For example, a 1981 article in the American Journal of Psychiatry reported that "prevalence among neuroleptic-treated psychiatric inpatients has been progressively rising and has reached 25% during the past five years."³⁵ More recent sources have found rates of tardive dyskinesia of 20-40%³⁶ and 50-60%³⁷ in chronically institutionalized patients. With increasing attention to diagnosing the disorder, moreover, "prevalence rates . . . grow year by year."³⁸ Even so, tardive dyskinesia con-

³³ Schatzberg and Cole, *supra* n. 28, at 98.

³⁴ Petitioners cite the American Psychiatric Association Task Force Report No. 18, which was published in 1980. Of the twenty-one studies used to determine the rate of prevalence of tardive dyskinesia, more than half (eleven) were from 1976 or earlier. Hundreds of articles and books documenting higher rates have appeared since that time. The American Psychiatric Association has conceded that this Task Force Report is out of date and is in the process of revising it. The new edition is expected to be published within the next year.

³⁵ Jeste and Wyatt, *Changing Epidemiology of Tardive Dyskinesia: An Overview* 138 American Journal of Psychiatry 297 (1981).

³⁶ Hollister, "Antipsychotic and Antimanic Drugs (Lithium)" in *Review of General Psychiatry* 507 (Goldman, ed. 1984).

³⁷ Schatzberg and Cole, *supra* n. 28, at 99.

³⁸ Gualtieri, Sprague and Cole, *Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic Treatment*, 14 Journal of Psychiatry and Law 187, at 206 (1986).

tinues to be underdiagnosed.³⁹

The effects of tardive dyskinesia are also greater than petitioner's amici would have the Court believe. Far from "rang[ing] from barely noticeable to being uncomfortable and unattractive,"⁴⁰ the effects can include the following: "in some cases, self-care, feeding and swallowing, as well as vocationally important dexterity can be impaired; severe cases, while infrequent, can be as disabling as Huntington's Disease."⁴¹ These horrible conditions are, unfortunately, far from rare. Tardive dyskinesia is "severe and persistent in about 25% of those affected."⁴² This estimate is probably low, since clinicians regularly underestimate the severity of their patients' tardive dyskinesia.⁴³ Reference works acknowledge that "[t]here is no effective or standard treatment for tardive dyskinesia."⁴⁴

In addition, petitioners and their amici completely ignore another devastating effect of these medications, neuroleptic malignant syndrome. That syndrome is caused by antip-

³⁹ In a recent study ten out of fifty-eight patients surveyed had tardive dyskinesia, but only one was accurately diagnosed by the clinician. The researchers noted that "without significant remediation of errors in diagnostic methods and training insufficiencies, it is likely that extrapyramidal side effects will continue to be underdiagnosed at an alarming rate." Weiden *et al.*, *Clinical Non-Recognition of Neuroleptic Induced Movement Disorders: A Cautionary Study*, 144 American Journal of Psychiatry 1148, 1151 (1987).

⁴⁰ Brief of Amicus American Psychiatric Association at 15.

⁴¹ Baldessarini, *Clinical and Epidemiological Aspects of Tardive Dyskinesia*, 4 Journal of Clinical Psychiatry (section 2) 8 (1985).

⁴² *TD Court Cases Underscore Importance of APA Report*, Psychiatric News, October 7, 1983, at 1.

⁴³ Rosen, Mukherjee, *et al.*, *Perceptions of Tardive Dyskinesia in Outpatients Receiving Maintenance Neuroleptic*, 139 American Journal of Psychiatry 372-73 (1982).

⁴⁴ Schatzberg and Cole, *supra* n. 28, at 100.

psychotic medication and is fatal in 25% of cases. Two 1986 studies found that "even a conservative estimate would place the annual prevalence of neuroleptic malignant syndrome in the United States in the thousands of cases, a significant number of which may have fatal consequences,"⁴⁵ and that the condition "remains underdiagnosed . . . [O]ur results and the remarkable increase of reported cases in recent years suggest that the prevalence needs to be reevaluated."⁴⁶

These drugs also have significant effects on mental processes. They are intended to affect the human brain and they do. Sometimes they promote clearer thinking. Unfortunately, psychopharmacologic technology is not yet so fine-tuned that other effects on a person's ability to think have been eliminated. The drugs that Harper took are commonly recognized as causing "drowsiness,"⁴⁷ "lethargy"⁴⁸, "confusion," "exacerbation of psychotic symptoms including hallucinations,"⁴⁹ and "catatonic-like behavioral states."⁵⁰ Textbooks discuss the "pseudo-

⁴⁵ Pope, Keck and McElroy, *Frequency of Presentation of Neuroleptic Malignant Syndrome in A Large Psychiatric Hospital*, 143 *American Journal of Psychiatry* 1227, at 1232 (1986).

⁴⁶ Addonizio, Susman and Roth, *Symptoms of Neuroleptic Malignant Syndrome in 82 Consecutive Inpatients*, 143 *American Journal of Psychiatry* 1587 (1986).

⁴⁷ This is listed in the 1989 Physician's Desk Reference as a common side-effect of Haldol, p. 1236; Prolixin, pp. 1640, 1642; Taractin, p. 1755; Loxitane, p. 1126; Mellaril, p. 1882. Navane, which Harper also took, is listed as producing reactions similar to these drugs.

⁴⁸ The 1989 Physician's Desk Reference lists "lethargy" as a common side-effect of Haldol, Prolixin, and Mellaril. See citations at n. 48. Navane is listed as causing "fatigue" at 1788.

⁴⁹ Almost all of the drugs administered to Harper are known to cause "paradoxical reactions", i.e. exacerbation rather than diminution of psychotic symptoms. See n. 48.

⁵⁰ Of the drugs with which Harper was involuntarily medicated, Trilafon, Haldol, Prolixin, and Taractin are known to cause catatonic-like behavioral states, even with administration of standard dosages. See n. 48.

depression," "toxic-confusional states," and "behavioral toxicity" produced by these drugs.⁵¹ The most common effect is slowing of the mental processes or sedation: "In chronic administration, sedation and fatigue often overlap with akinesia, a side effect characterized by inertia, inactivity, and lack of spontaneous movement."⁵²

These effects are frightening and serious. Unfortunately, they often go unnoticed or misdiagnosed. When patients complain of these side effects, psychiatrists sometimes suspect patients of feigning their rigidity or uncontrollable restlessness in order to avoid being drugged. This is true even when it is patently obvious that the side effects could not be the result of malingering.⁵³ In fact, in this case, Harper's psychiatrist suspected him of feigning the side effects which led him to refuse the medication.⁵⁴

Antipsychotic medication is intended to be used as part of a carefully monitored treatment plan in a psychiatric setting. Yet they often do not even work in the environment and for the

⁵¹ Hollister, "Antipsychotic and Antimanic Drugs (Lithium)" in *Review of General Psychiatry* 1984 at 596; Davis, "Antipsychotic Drugs," in Kaplan and Sadock, *Comprehensive Textbook of Psychiatry IV* (1985) at 1509-1510.

⁵² Schatzberg and Cole, *supra* n. 28, at 88.

⁵³ In one typical case, a hospital forced Thorazine on a woman with an affective disorder. The patient, who had tardive dyskinesia, was willing to accept lithium but refused Thorazine, a drug she recognized as inappropriate for her condition. An independent psychiatrist later characterized the hospital's choice as "grossly irresponsible," particularly in light of the severity of the patient's tardive dyskinesia. Hospital staff responded that they had believed she was faking the spasms and facial grimaces produced by tardive dyskinesia in order to avoid the Thorazine. Brotman, "Behind the Bench of Rennie v. Klein," in Doudera and Swazy, *Refusing Treatment in Mental Institutions: Values in Conflict* 56, 59 (1982).

⁵⁴ Finding of Fact 10, Pet. B-8.

population for whom they are intended. In fact, the recent psychiatric literature shows that a substantial number of patients are not helped at all by them. Between 20% and 25% of patients improve without any medication;⁵⁵ about 20% do not respond to medication at all,⁵⁶ even more relapse although they continue to be compliant with medication⁵⁷; and still others

⁵⁵ A leading textbook of psychiatry notes, "There are psychotic patients who improve without drugs. This fact is clearly documented in the NIMH collaborative study in which approximately 1 out of 4 patients showed a significant degree of improvement without medication." Davis, "Antipsychotic Drugs," in Kaplan and Sadock, eds., *Comprehensive Textbook of Psychiatry IV* 1487 (1985). See also Fenton and McGlashan, *Sustained Remission in Drug Free Patients*, 144 *American Journal of Psychiatry* 1306 (1987); Hogarty, Goldberg and Schooler et al, *Drugs and Sociotherapy in the Aftercare of Schizophrenic Patients II*, 31 *Archives of General Psychiatry* 607 (1974).

⁵⁶ Brown and Herz, *Response to Neuroleptic Drugs as a Device of Classifying Schizophrenia*, 15 *Schizophrenia Bulletin* 123 (1989). Brown cites to a study of 61 schizophrenic patients, 25 were "poor responders," 15 were "partial responders" and 21 were "good responders." Thus, almost 41% of patients did not benefit at all from neuroleptic drugs. Kolakowska et al. *Schizophrenia with Good and Poor Outcome*, 146 *British Journal of Psychiatry* 229 (1985). In another study, close to half of patients on neuroleptic either improved or remained unchanged when drugs were withdrawn totally or dosages drastically reduced. Shumway et al, *80% Neuroleptic Reduction in Chronic Psychotics*, Presented at the 140th Annual Meeting of the American Psychiatric Association, Chicago, Illinois, May 1987, cited in Brown et al., above.

⁵⁷ The maintenance treatment literature "shows that many patients (approximately 30%) relapse despite receiving neuroleptic medication, while neuroleptics can be withdrawn from other patients for many months and in some cases years without relapse." Lieberman, Kane, Sarantakos, et al., replying to Letter "Ethics of Drug Discontinuation Studies in Schizophrenia," 46 *Archives of General Psychiatry* 387 (April 1989) citing Davis, Schaffer et al., *Important issues in the drug treatment of schizophrenia*, 6 *Schizophrenia Bul-*

experience a worsening of symptoms with medication. Thus, for a significant proportion of psychiatric patients, these drugs are not helpful. Although it is impossible to predict with certainty which patients will be helped by these drugs, research shows that one of the best predictors of whether a drug will be beneficial to a patient is the patient's own subjective response to the drug.⁵⁸ Patients who have an extremely negative reaction to the drug are also those whose symptoms do not abate and may worsen.⁵⁹

In addition, there is a considerable body of literature which shows that these drugs are less effective when forced on an unwilling patient than when accepted voluntarily.⁶⁰ Even this

letin 70-87 (1980) and Kane and Lieberman, "Maintenance pharmacotherapy in schizophrenia," in Meltzer, ed., *Psychopharmacology, the Third Generation of Progress*, at 1103-1109.

⁵⁸ In one typical study, patients were asked to report their reactions to a regimen of thiothixene, also known as Navane, a drug Walter Harper received. The patients were rated prior to and during the drug therapy on seven different scales by psychiatrists and nurses who did not know the patients' reactions to the drugs. Patients with an initial "dysphoric" or negative reaction to medication had much worse treatment outcomes: only 14% showed unequivocal improvement, as opposed to 74% of patients who had a positive or "syntonic" response to the medication. Some "dysphoric" responders, "although cooperative and clam to start with, became acutely panicked and objectively more disorganized several hours after the first dose." Van Putten and May, *Subjective Responses as a Predictor of Outcome in Pharmacotherapy*, 35 *Archives of General Psychiatry* 477 (1978).

⁵⁹ Van Putten and May, *supra* at n. 58.

⁶⁰ Rogers and Webster, *Assessing Treatability in Mentally Disordered Offenders*, 13 *Law and Human Behavior* 19, 20 (1989); Nicholson, *Correlates of Commitment Status in Psychiatrist Patients*, 100 *Psychological Bulletin* 241-250 (1986); Gove and Fain, *A Comparison of Voluntary and Committed Psychiatric Patients*, 34 *Archives of General Psychiatry* 669-676 (1977).

Court has noted that "one of the few areas of agreement among behavioral specialists is that an uncooperative patient cannot benefit from therapy."⁶¹ Many of the studies cited by petitioners and amici regarding effectiveness of these drugs are limited by the fact that the subjects of many of the studies were willing patients rather than individuals being forcibly medicated.

"[F]ew legitimate medical procedures . . . are more intrusive than the forcible injection of antipsychotic medication . . . [b]ecause of both the profound effect that these drugs have on the thought processes of an individual and the well-established likelihood of severe and irreversible adverse side-effects"⁶² Mr. Harper's interest in avoiding the forced administration of antipsychotic medication is most compelling. Ultimately that interest includes avoiding side-effects that can be disabling and lead to death.⁶³

⁶¹ *O'Connor v. Donaldson*, 442 U.S. 563, at 579 (1975) (Burger, C.J., concurring).

⁶² *In re Roe*, 421 N.E.2d 40, at 52-53 (Mass. 1981). The mistaken administration of antipsychotic drugs to a nonpsychotic individual can result in that individual developing a "toxic psychosis," causing him to suffer symptoms of psychosis." *Id.* at 53.

⁶³ "Perhaps the best description of the effects of these drugs on the mind was given by a prisoner who received them: 'There is no other feeling like it. Nothing to relate it to, no experience anyone would normally go through in their life. It affects you mentally and physically and you feel suicidal. The physical effects are so bad you can't stand it. You get muscle spasms, predominantly in the legs, but also in all other parts of the body including your facial muscles Your thoughts are broken, incoherent; you can't hold a train of thought for even a minute. You're talking about one subject and suddenly you're talking about another. You start to roll a cigarette, drop it, pick up a book Your mind is like a slot machine, every wheel spinning a different thought . . . the thought of suicide keeps recurring in order to alleviate, once and for all, the torturous effects of the drug.'" Opton, *Psychiatric Violence Against Prisoners: When Therapy is Punishment*, 45 Miss. Law Journal 605, at 641 (1974).

Especially in this context, the spectre of a state forcing medical treatment on an unwilling individual is antithetical to the right to privacy which "embodies the 'moral fact that a person belongs to himself and not others nor to society as a whole.'" *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, at 777 n. 5 (1986).

The cost of an erroneous determination is higher than in *Vitek v. Jones*, 445 U.S. 480 (1980). Depriving an individual of the right to decide for himself whether to take drugs that will affect his brain deprives him of the most fundamental aspect of his own humanity.⁶⁴ This interest is obviously far stronger than the interest protected in *Vitek v. Jones*. The prisoner in that case had already lost his liberty: his two protected interests were in freedom from stigma associated with the label of mental illness and to avoid being erroneously subjected to behavior modification programs. While such programs can be noxious and clearly implicate a liberty interest, a prisoner can always "refuse" them simply by failing to cooperate. Neither body nor mind are invaded with the chemical totality of drugs. This case presents the issue of involuntary intrusion on both body and mind, with permanent and possibly fatal consequences. Depriving a competent individual of this choice about his body truly would "draw an iron curtain between the prisons and the Constitution."⁶⁵

B. The Risk Of An Erroneous Deprivation Of Respondent's Interest Through The Internal SOC Procedure Is Great.⁶⁶

⁶⁴ "[C]ontrol over the body is the first form of autonomy and the necessary condition, for those who are not saints or stoics, of all later forms. For most of us this will be self-evident: if we don't control our bodies, what do we control?—and indeed who are we? The body is the necessary condition of both identity and autonomy." Gerety, *Redefining Privacy*, 12 Harvard Civil Rights-Civil Liberties Law Review, 233, at 266 and n. 119 (1977).

⁶⁵ See *Wolff v. McDonnell*, 418 U.S. 539, at 555-56 (1974).

⁶⁶ A threshold problem with this factor in this case is that when

The misuse of drugs is especially common in prisons,⁶⁷ where there tend to be fewer psychiatrists and neither the resources nor the environment for providing treatment: "Prisons are first and foremost institutions of discipline and control. Major tranquilizers are effective chemical control agents. The temptation to use them is great, particularly since they are more efficient than physical methods of control and require much less of a commitment of staff and time."⁶⁸ Psychiatry textbooks acknowledge that the problem is widespread: "[o]bservers of the prison system in the United States have been particularly critical of the haphazard ways in which psychopharmacological agents are dispensed."⁶⁹

The SOC procedures are likely to lead to errors from four different perspectives. First, the decision to medicate is likely to be made for reasons of behavior control rather than treatment. Second, the decision to medicate is made wholly from

competent individuals make their own treatment decisions, there is no such thing as an "erroneous" decision. Petitioner and their amici measure an "erroneous" decision as one that is, from a medical standpoint, inadvisable. This might be more applicable in a case such as *Vitek v. Jones*, 445 U.S. 480 (1980); both the prisoner and the state would agree that an "erroneous" decision to transfer a prisoner to a mental hospital was made if the prisoner is in fact not mentally ill. The assessment of whether an individual is mentally ill does involve medical judgment. But an individual's personal decision regarding his medical treatment may involve other factors besides medical judgment and is not susceptible to an objective determination of whether it is "erroneous." See part III C, *infra*.

⁶⁷ See Kaufman, *The Violation of Psychiatric Standards of Care in Prison*, 137 Am. J. Psychiatry 566, at 568 ("Many of the abuses of psychiatry in prison relate to the misuse of psychotropic drugs." Recounting death of prisoner due to psychotropic medication given without adequate monitoring.).

⁶⁸ Sitnick, *Major Tranquilizers in Prison: Drug Therapy and the Unconsenting Inmate*, 11 Williamette L.J. 378, at 387-88 (1975).

⁶⁹ Kaplan and Sadock, *supra* n. 55, at 1995.

within the institution with no external control. Third, as conducted, the hearing designed to review the decision to medicate provided no real opportunity for Mr. Harper to present his case. Fourth, the standards governing the decision making process (e.g. there is no clearly articulated showing that the state must make to overcome Harper's liberty interest nor is there an articulated standard of proof) invite error.

Decisions to forcibly medicate a prisoner made by prison authorities are likely to be made for reasons of behavior control rather than to treat a mental illness. The punitive orientation of most prisons is antithetical to successful mental health treatment: "[m]any prisons offer inmates an emotional climate that is destructive to most goals of [psychiatric] rehabilitation."⁷⁰

Drugs have, unfortunately, often been (mis-)used to control inmates under the guise of "treatment." At Atascadero State Hospital in California, the drug Anectine was administered to patients having behavioral problems, that is, to patients whose behavior offended the staff.⁷¹ Anectine causes the patient to experience feelings of suffocating and death.⁷² "Within 30-40 seconds of injection it brings on paralysis As a result, the patient cannot move or breath, and yet remains fully conscious."⁷³

The psychotropic drugs used to control Mr. Harper have also been used elsewhere for behavior control. *Riese v. St. Mary's Hospital*, 243 Cal.Rptr. 245 (Cal. App. 1987), dismissed as improvidently granted, Calif. Supreme Court cause no

⁷⁰ Kaplan and Sadock, eds., *supra* n. 55 at 1991.

⁷¹ Serber, Hiller, et. al., *Behavior Modification in Maximum Security Settings: One Hospital's Experience*, 13 American Criminal Law Review 85, at 90 (1975).

⁷² *Id.*

⁷³ *Id.* The Ninth Circuit has found that the use of Anectine raised Eighth Amendment issues. *Mackey v. Procunier*, 477 F.2d 877 (9th Cir. 1973).

S004002 (June 22, 1989); *Davis v. Hubbard*, 506 F. Supp. 915, at 926 (N.D. Ohio 1980) ("the testimony at trial established that the prevalent use of psychotropic drugs is countertherapeutic and can be justified only for reasons other than treatment—namely, for the convenience of the staff and for punishment");⁷⁴ *Rennie v. Klein*, 476 F.Supp. 1294, at 1299 (D.N.J. 1979) ("the medical director of Marlboro states in an office memorandum that the hospital 'uses medication as a form of control and as a substitute for treatment.'").

It is clear from the record herein that the drugs were used to control aggressive behavior and as punishment. The only justification cited by the trial court for medicating Harper involuntarily was that his history "include[d] incidents of assaultive behavior" and that, as a result of a mental disorder which he suffered, he "constituted a likelihood of serious harm to others." Findings of Fact 5, 11. Pet. B-5, B-8. The trial court did not find that the medications were prescribed to benefit or treat Harper, or that they did have that effect. This raises a strong inference that the drugs were used as punishment for disciplinary infractions. The use of psychotropic medications on Harper is unfortunately quite typical of the use of these drugs for behavior control and punishment in prisons.⁷⁵

⁷⁴ "Psychotropic drugs are not only overprescribed; they are also freely prescribed. They are prescribed by both licensed and unlicensed physicians. Both licensed and unlicensed physicians regularly prescribe drugs for any patient in the institution without regard to whether he is personally assigned to the patient or whether he has even seen the patient." *Davis v. Hubbard*, 506 F. Supp. at 926.

⁷⁵ See e.g. *Girouard v. O'Brien*, No. 83-3316-0 (D. Kansas, April 4, 1988) at 2 (prisoner medicated for being "boisterous"); *Kendrick v. Bland*, 541 F. Supp. 21, at 25 (W.D. Ky 1981); *Lightfoot v. Walker*, 486 F. Supp. 504, at 522 (S.D. Ill. 1980); *Ruiz v. Estelle*, 503 F. Supp. 1265, at 1332 (S.D. Tex 1980). See also Kaufman, *The Violation of Psychiatric Standards of Care in Prisons*, 137 Am.J. of Psychiatry 566, at 567-68 (1980).

When Mr. Harper refused to take antipsychotic medications, a three member panel of SOC personnel was convened to decide whether medications should be involuntarily administered. Finding of Fact 3c, 6, Pet. B-3, B-5. Two members of the panel were not licensed to prescribe antipsychotic medication and therefore would be unlikely to discern the inappropriate use thereof. *Id.* In addition, the panel by its composition is predisposed to give greater weight to penal objectives than to an individual prisoner's problems with his medication. The panel cannot be impartial or unbiased. It is made up entirely of prison officials, including a prison administrator, a prison psychiatrist, and a prison psychologist. The latter two people are mental health professionals and therefore are philosophically oriented in favor of providing treatment to the patient; all three are interested in maintaining control in the facility. While these concerns are not illegal or immoral, they are also not consistent with a disinterested decision concerning the rights of an individual. Because no person from outside SOC serves on the panel, its members review requests by their colleagues to forcibly treat a prisoner; these same colleagues will later sit on panels deciding whether to forcibly medicate their own patients.⁷⁶

The problems created by an internal set of decision-makers are far more troublesome in this case than in *Vitek v. Jones*, 445 U.S. 480 (1980). In *Vitek*, if the decision-maker from within the prison was influenced by administrative considerations in deciding to transfer a prisoner, he or she was subject to a check

⁷⁶ On November 23, 1982, when the course of involuntary treatment began for Mr. Harper, the treating physician who recommended such treatment was Dr. Petrich. Findings of Fact 5, 6, Pet. B-5. Two weeks later when the initial decision to involuntarily medicate was reviewed, Dr. Petrich was a member of the panel, another physician having recommended continuation of the involuntary treatment. Finding of Fact 6, Pet. B-6. In fact, four physicians, at various times, were either the treating physician or a member of the reviewing panel. Finding of Fact 7, Pet. B-7.

on the other side of a transfer—presumably the mental hospital in question could refuse to accept the prisoner or transfer him back to prison if professionals at the hospital felt that the transfer was improper. Here the decision is, in effect, “all in the family,” and there is no outside review permitted by the regulations, nor is there any opportunity to appeal an adverse decision to the courts.

The procedures are also likely to lead to error even if the panel (hearing committee) was made up of psychiatrists from outside the prison because a prisoner is not allowed to hear why the professional staff believes that he should be medicated. “[P]rior to the hearing, the hearing committee members would consult with the staff outside the presence of the plaintiff for the purpose of ascertaining whether the requirements of the policy had been met and what the position of the staff would be at the hearing. SOC staff members would summarize their position for the hearing committee by briefly presenting their reasons as to why the plaintiff was dangerous and why his condition was a product of a mental disorder. Mr. Harper would then be brought into the hearing which would take place in accordance with the policy. Mr. Harper would then be excused during the committee’s deliberations [and] brought back to be informed of the decision” Finding of Fact 7, Pet. B-6. Mr. Harper had no counsel; SOC policy does not allow for representation by counsel. Finding of Fact 7, Pet. B-6.

Under such conditions Mr. Harper’s opportunity to a real hearing and to meaningful cross examination is utterly denied. Because Mr. Harper was unable to refute the treating psychiatrist’s arguments (he did not know them), he had no ability to present his side of the issue. Similarly the panel (or hearing committee) was incapable of acting as a neutral fact-finder because its capacity to fairly hear both sides of the story was distorted.⁷⁷

⁷⁷ See *Ford v. Wainwright*, 477 U.S. 399, at 415 (1986). “Cross examination of the psychiatrists, or perhaps a less formal equivalent, would contribute markedly to the process of seeking truth in sanity

The standards (actually one might say the absence of standards) are so broad and vague that they are not only likely but certain to lead to error. The standard for medication—the prisoner “suffers from a mental disorder and as a result of which is either gravely disabled or presents a likelihood of serious bodily harm to himself or others”—⁷⁸ is so broad that all prisoners at SOC and most in the prisons across the country could be swept in under them. “The fact that a person has been found, beyond a reasonable doubt, to have committed a criminal act certainly indicates dangerousness.” *Jones v. United States*, 463 U.S. 354, at 364 (1983). Many of the prisoners at SOC are mentally ill, and estimates of the rate of mental illness in American prisons range widely, but many studies show that a majority of prisoners in America today suffer from mental illness.⁷⁹ Therefore, a majority of American prisoners could

disputes by bringing to light the bases of each expert’s beliefs, the precise factors underlying those beliefs, any history of error or caprice of the examiner, . . . the expert’s degree of certainty about his or her own conclusions and the precise meaning of ambiguous words used in the report. Without some questioning of the experts concerning their technical conclusions, a factfinder simply cannot be expected to evaluate the various opinions, particularly when they themselves are inconsistent.”

⁷⁸ Finding of fact 3a, Pet. B-3. The hearing committee’s standard of “review” is particularly troublesome: “The Committee decides . . . whether the patient is gravely disabled or dangerous”

⁷⁹ One article cites studies ranging from 3% to 63%, Kaufman, *The Violation of Psychiatric Standards of Care in Prison*, 137 *American Journal of Psychiatry* 566 (1980); other studies show figures of 15-25%; American Correctional Association, *Manual of Correctional Standards*, 441-442 (1968); with more recent estimates showing a higher number, including as high as 75%, Kaplan and Sadock, *supra* n. 55, at p. 1991. Prisons have a greater population presenting behavior problems not caused by mental disorder, or people with personality disorders as opposed to true psychoses. These populations present behavior problems not caused by mental disorders, or people with personality disorders as opposed to true psychoses. These populations are difficult to handle and can increase the temptation to use psychotropic medications inappropriately.

probably be subjected to involuntary medication with psychotropic drugs under the SOC standard, no matter how brief their sentence or relatively light the offense. The standards do not require a prisoner to be found incompetent. They do not even require a finding that the medication will benefit the prisoner.

There is no requirement that the hearings be conducted in accordance with the rules of evidence. There is no articulated burden of proof.⁸⁰

Finally, because the medications are administered in a closed correctional setting, the likelihood of discovery of erroneous use is slight. Prisons "are closed institutions to which public and media have very limited access. Abuses in such circumstances are extremely difficult to discover or control."⁸¹

C. The Probable Value Of A Judicial Hearing Is Substantial.

A judicial hearing with its attendant rights would substantially reduce the risk of an erroneous deprivation of Respondent's protected liberty interest. As discussed in Part III B above, when the decision to medicate is made within the institution there is a great risk of error. That risk, in the main, flows from the institutional capabilities (or lack thereof) and the institution's need to control the behavior of inmates.

In the opinion below, the Washington State Supreme Court held that a judicial hearing was required before a prisoner could be involuntarily administered antipsychotic medication.⁸² In doing so, the court also enunciated the showing that the state must make to overcome a prisoner's liberty interest in

⁸⁰ In the opinion below, the court held that the state's burden was "clear, cogent and convincing evidence." Pet. A-11.

⁸¹ Sitnick, *Major Tranquilizers in Prison: Drug Therapy and the Unconsenting Inmate*, 11 *Williamette L.J.* 378, at 387-88 (1975).

⁸² Pet. A.

refusing antipsychotic medication.⁸³ In addition, the court held that the state's burden of proof is by "clear, cogent and convincing evidence."⁸⁴ These procedures insure, to a degree unattainable in the institutional setting, that the medication will not be erroneously administered.

An individual's decision to accept or forego treatment is not a medical question.⁸⁵ That decision may be based on many factors other than the optimal medical course of action. For example, Justice Robert Jackson was advised by his doctors after suffering a severe heart attack that he must cease his activities on the Court or face the risk of death at any minute. His choice to ignore "professional judgment" was treated with respect by his colleagues, although his refusal to give up his normal activities did lead to his death shortly thereafter. "With characteristic fortitude, he chose the latter alternative."⁸⁶

In fact, the protection of the law becomes most important when such decisions are not the medically optimal course. In

⁸³ The state must prove "(1) a compelling state interest to administer antipsychotic drugs, and (2) the administration of the drugs is both necessary and effective for furthering that interest." Pet. A-10. The court also listed four nonexclusive criteria for determining a compelling state interest. *Id.* At this point, the inquiry turns to the necessity for and effectiveness of the proposed treatment. *Id.*

⁸⁴ Pet. A-11. Other due process rights attendant upon any adversary judicial hearing were confirmed as also being required. *Id.*

⁸⁵ The Washington Supreme Court recognized this principle in its opinion below. In deciding whether the treatment is necessary, trial courts are directed to "consider the patient's desires before entering an order. The court should consider previous and current statements of the patient [and] religious and moral values of the patient regarding medical treatment If the patient appears unable to understand fully the nature of the . . . hearing . . . the court should make a 'substituted judgment' for the patient that is analogous to the medical treatment decision for an incompetent person." Pet. A-10, 11 (citations omitted).

⁸⁶ 99 L.Ed.2d 1312.

applying the privacy right to the right to refuse medical treatment, then Judge Burger first quoted Justice Brandeis' famous declaration:

The makers of our Constitution . . . sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized man.

Judge Burger then noted that

Nothing in this utterance suggests that Justice Brandeis thought an individual possessed these rights only as to sensible beliefs, valid thoughts, reasonable emotions, or well-founded sensations. I suggest he intended to include a great many foolish, unreasonable, and even absurd ideas which do not conform, *such as refusing medical treatment even at great risk.*

Application of President and Directors of Georgetown College, 331 F.2d 1010, 1015 (D.C. Cir. 1964) (Burger, dissenting) (Emphasis deleted, emphasis added), *cert. denied* 337 U.S. 978 (1964). This is true regardless of whether the decision represents the medically optimal course of action.⁸⁷ To characterize this fundamental individual right to make one's own decisions regarding medical treatment as merely a medical question which ought to be left to psychiatrists is akin to calling *Brown v. Board of Education* a case involving educational policy which ought to be left to professional educators, or the decision to represent one's self in a criminal matter a strictly legal ques-

⁸⁷ "The very foundation of the doctrine [of informed consent] is every one's right to forego treatment or even cure if it entails what *for him* are intolerable consequences or risks, however warped or perverted his sense of values may be in the eyes of the medical profession, or even of the community, so long as any distortion falls short of what the law regards as incompetency. Individual freedom here is guaranteed only if people are given the right to make choices that would generally be regarded as foolish ones." 2 Harper, James, & Gray, *The Law of Torts*, Sec. 17.1 (2d Ed. 1986) (Emphasis in original).

tion, with the individual's decision to be overruled by lawyers if it is legally sound in their professional judgment.⁸⁸

In a free society, many decisions an individual is allowed to make for himself appear to have a considerable and negative impact on the individual's life⁸⁹ and are contrary to professional judgment. Because those decisions involve personal values, they are left under our Constitution to the individual. Even if the odds are in favor of Harper being benefited by psychotropic drugs, he might also be severely damaged by them, and "personal liberties are not rooted in the law of averages." *Farretta v. California*, 422 U.S. 806, at 834 (1975). Even if his choice is "ultimately to his own detriment, his choice must be honored out of 'that respect for the individual which is the life-blood of the law.'" *Id.* (quoting *Illinois v. Allen*, 397 U.S. 337, at 350-51 (1970)).

For these reasons, the decision of whether or not to accept treatment has always been reserved by the common law to the competent individual. *Schloendorff v. Society of New York*

⁸⁸ *Farretta v. California*, 422 U.S. 806 (1975). "It is one thing to hold that every defendant, rich or poor, has the right to the assistance of counsel, and quite another to say that a State may compel a defendant to accept a lawyer he does not want . . . whatever else may be said of those who wrote the Bill of Rights, surely there can be no doubt that they understood the inestimable worth of free choice." *Id.* at 883.

⁸⁹ The highest court in Maryland recently held that a defendant rather than his attorney has the final decision whether to assert lack of criminal responsibility due to mental incapacity, even when the defendant's refusal to enter such a plea is in the lawyer's opinion a legally disastrous choice resulting from the very incompetence the defendant refuses to assert. *Treece v. State of Maryland* 547 A.2d 1054, 1062 (Md. 1988). "In a free society an individual faced with a choice of this sort should be allowed to make it and live with its consequences, notwithstanding that society deems the choice inappropriate." *Id.* The court emphasized that Treece had never been adjudicated incompetent. *Id.* at 1056.

Hospital, 105 N.E. 92, at 93 (N.Y. 1914). Although a physician may raise the issue of competence if he suspects his patient is not competent, and indeed has the legal and ethical duty to do so, whether an individual is competent or not has traditionally been a question decided by the courts. "[T]he task for the court is simply to determine whether a patient refusing medication is competent to do so despite his or her mental illness. The determination of this capacity 'is uniquely a judicial, not a medical function.'"⁹⁰

The decision to be made here is one of a prisoner's competence to refuse medication. That is not a decision to be left to a psychiatrist, psychologist and an administrator. "Competency" is a legal status that cannot be treated and cured as if it were a disease. Its determination cannot be delegated to doctors. "When medical judgments collide with a patient's fundamental rights . . . it is the courts, not the doctors, who possess the necessary expertise."⁹¹ While the decision that a person could benefit from antipsychotic drugs undeniably entails professional medical judgment, the decision to force those drugs on the person "directly implicates the patient's legal interest in personal autonomy and bodily integrity" and must be judicially determined.⁹² This decision can no more be left to doctors than the determination of whether a person was competent when he or she wrote a will, whether a person is competent to stand trial, whether a person is competent to give evidence in court, or whether a person is competent to control his or her own estate. All of these issues are decided by a judge, usually with

⁹⁰ *Riese v. St. Mary's Hospital*, 243 Cal. Rptr. 241, at 253 (Cal. App. 1987) (dismissed as improvidently granted, Calif Supreme Court cause no. S004002, June 22, 1989) quoting *Rivers v. Katz*, 495 N.E.2d 337, at 343 (N.Y. 1986). See also *Opinion of the Justices*, 465 A.2d 484, at 488 (N.H. 1983); *In re K.K.B.*, 609 P.2d 747, at 749 (Okla. 1980).

⁹¹ *Jarvis v. Levine*, 418 N.W.2d 139, at 147-48 (Minn. 1988).

⁹² *People v. Medina*, 705 P.2d 961, at 968 (Colo. 1985).

input and guidance from the medical profession. The issue of competence to refuse medication is just as clearly the province of the judge, if not more so, since it involves the fundamental right of security in one's body and mind.⁹³

Legal authorities are unanimous that mental illness does not necessarily render a person incompetent to make medical choices.⁹⁴ For such competent individuals, both the law and medical ethics require informed consent before beginning treatment.

Involuntary treatment is therefore only justified by the state *parens patriae* interest in treating people in its custody if the individual is incompetent to make his own treatment decisions.⁹⁵ In the absence of emergencies, prisoners, like all people, should be able to make their own treatment decisions.

Decisions to comply with or forego recommended treatment are affected not only by medical factors, but by "lifelong belief systems, future plans, family relationship patterns, social

⁹³ Washington, as do most states, expressly provides that a civilly committed person does "not forfeit any legal right or suffer any legal disability as a consequence . . . [of civil commitment] other than as specifically provided in this chapter." Wash. Rev. Code sec. 71.05.060; see 71.05.360; Parry, "Incompetency Guardianship, and Restoration," in Brakel, Parry, & Weiner, *The Mentally Disabled and the Law* at 375, table 7.2 (1985) (containing a survey of the relationship between involuntary commitment and legal competence in state statutes).

⁹⁴ See, e.g. *Matter of Orr*, 531 N.E.2d 64, at 73 (Ill. App. 1988) ("an involuntarily committed person is not necessarily legally incompetent"); *Winters v. Miller*, 446 F.2d 65, at 68 (2nd Cir.) cert. denied, 404 U.S. 985 (1971) ("A finding of 'mental illness' even by a judge or jury and commitment to a hospital, does not raise even a presumption that the person is incompetent."); *Davis v. Hubbard*, 506 F.Supp. 915, at 935 (N.D. Ohio).

⁹⁵ *In re K.K.B.*, 609 P.2d 747, at 750 (Okla. 1980).

roles, and self-concept."⁹⁶ This is as true of psychiatric patients as of non-psychiatric patients. It is a myth that refusal of psychotropic medication is solely due to mental illness. Like other patients, psychiatric patients reject treatment for religious reasons,⁹⁷ because they are pregnant,⁹⁸ because they prefer the effects of the illness to the effects of the medication,⁹⁹ because the side effects of a particular drug are unbearable,¹⁰⁰ and sometimes simply because they are receiving the wrong medication or the wrong dose.¹⁰¹

⁹⁶ Gerber, "Compliance in the Chronically Ill: An Introduction to the Problem," in Gerber and Nehemkis, *Compliance: The Dilemma of the Chronically Ill* at 19 (1986).

⁹⁷ *In re Boyd*, 403 A.2d 744 (D.C. 1979); *Winters v. Miller*, 446 F.2d 65 (1971); *In re Milton*, 505 N.E.2d 255 (Ohio 1987).

⁹⁸ This reason arises surprisingly often. See e.g. Brotman, "Behind the Bench in Rennie v. Klein," in Doudera and Swazy, *Refusing Treatment in Mental Institutions: Values in Conflict*, 34 (1982); *State ex rel Jones v. Gerhardstein*, 416 N.W.2d 883, at 891 (Wisc. 1987); Keisling, *Characteristics and Outcome of Patients who Refuse Medication*, 34 Hospital and Community Psychiatry 847 (1983) (one of nine patients who refused treatment and was subsequently forcibly medicated was pregnant).

⁹⁹ Van Putten, Crumpton and Yale, *Drug Refusal in Schizophrenia and the Wish to be Crazy*, 33 Archives of General Psychiatry 1443 (1976).

¹⁰⁰ One study examining the reasons for refusing treatment found that patients refused drugs because of side effects more than any other reason. The patients cited effects such as "blurred vision" "confused feelings" "sick to my stomach" and "harmful to my health" in the case of a woman with tardive dyskinesia. Hassenfeld and Grument, *A Study of the Right to Refuse Treatment*, 12 Bulletin of the American Academy of Psychiatry and the Law 65, at 70 (1984).

¹⁰¹ For example, in one article the authors note that one of five medication refusers "reported after recovery that she had been convinced that the staff had been giving her an incorrect medication that led to her confusion. In fact measurement of plasma trycyclic anti-

Sometimes both non-psychiatric and psychiatric patients refuse treatment as a way of assuring themselves that they are actually in control of, and can make decisions about, their bodies: "[o]nce [psychiatric] patients are sure they have real control over their medication, that they can in fact refuse the medication, they often feel safer in agreeing to take the medication."¹⁰² Like Harper, both non-psychiatric and psychiatric patients accept treatment at some times but not at others. The ability to do this can be important to a patient's recovery, for both the psychiatric and non-psychiatric patient.¹⁰³

In the face of this, petitioners and their *amici* propose a truly revolutionary departure from common law and precedent stretching back hundreds of years: they propose to completely

depressant levels revealed them to be in a markedly toxic range." In other words, the patient's perception that something was wrong with her medication before her "recovery" had been correct. Appelbaum and Gutheil, *Drug Refusal, A study of psychiatric inpatients*, 137 American Journal of Psychiatry 340, at 342-43 (1980).

¹⁰² Diamond, *Enhancing Medication Use in Schizophrenia Patients*, 44 Journal of Clinical Psychiatry 14 (1983).

¹⁰³ Appelbaum and Hoge concede that "a prolonged treatment refusal paradoxically may be taken as a sign that a patient still retains a determination to exercise control over his or her situation, and thus perhaps has a better prognosis for treatment. Follow-up data from patients who refuse treatment . . . partially support this belief." Appelbaum and Hoge, *Empirical Research on the Effects of Legal Policy on the Right to Refuse Treatment in The right to Refuse Antipsychotic Medication* (ABA 1986). A similar phenomenon is reported among non-psychiatric patients by Farberow: "non-complaint acts are . . . declarations of an inner core of self, indomitable and unconquered. To some degree they insist that the body, ravaged as it may be by disease or injury, is still personal and not a meaningless collection of fat, tissue, nervous system, and bones that has been taken over by the illness, by the medical profession or by both." Farberow, "Noncompliance as Indirect Self-Destructive Behavior," in Gerber and Nehemkis, *Compliance: The Dilemma of the Chronically Ill*, at 41.

eliminate the requirements of informed consent for competent individuals to accept medical treatment. The entire class of committed individuals, pre-trial detainees, and prisoners would no longer be granted any rights to make treatment decisions. The preference of the person treated, according to the American Psychiatric Association, is legally irrelevant: they ask this Court to enshrine the doctor's treatment preferences as the only legally relevant consideration. This is a complete reversal of the current legal requirement: "The right to refuse medical treatment is basic and fundamental . . . Its exercise requires no one's approval. It is not merely one vote subject to being overridden by medical opinion."¹⁰⁴ Not surprisingly, the state proposes that the Court use a standard grafted from a case, *Youngberg v. Romeo*¹⁰⁵ which did not discuss privacy, and which was intended for totally different purposes.

The *Youngberg v. Romeo* professional judgment standard is not applicable to this case. A fundamentally different inquiry is presented herein than was presented in *Youngberg*. Romeo was a profoundly retarded thirty-three year old man with an I.Q. between 8 and 10 who had the mental capacity of an 18-month old child.¹⁰⁶ He had been committed to a state hospital by court order.¹⁰⁷ He was seeking appropriate treatment, Mr. Harper is not. Mr. Harper has not, by a court order, been determined incompetent. He was not, by the sentencing court committed for treatment with antipsychotic drugs. The sentencing court, it can be assumed, did not anticipate that one of the conditions of its sentence would be the involuntary administration of antipsychotic medications.

Youngberg does not apply at all to decisions in prison settings to use drugs for purposes of behavior control. If it were other-

¹⁰⁴ *Bouvia v. Superior Court*, 225 Cal.Rptr. 297, at 301 (Cal. App.1986).

¹⁰⁵ 457 U.S. 307 (1982).

¹⁰⁶ *Id.* at 309.

¹⁰⁷ *Id.* at 309-310.

wise, psychiatry would become a tool of the warden rather than a healing profession.

Even if the state's motivation were solely treatment, however, *Youngberg* would still not apply. There, an individual in custody in a treatment facility asserted a constitutional right to treatment and habilitation by the Government, and demanded that those services and treatment be provided in the least restrictive alternative setting. The Court held that as long as the services provided were in accord with professional judgment, the providers could not be held liable. As this Court noted recently, the *Youngberg* case concerns the scope of the state's duty to provide services and care to those in its custody. *DeShaney v. Winnebago County Department of Social Services*, 57 U.S.L.W. 4218, at 4220-21 (Feb. 22, 1989). The professional judgment standard of *Youngberg* reflected the Court's unwillingness to arbitrate between experts disagreeing on the optimal treatment for already institutionalized individuals and was developed to "limit judicial review of challenges to conditions in state institutions." *Youngberg*, 457 U.S. at 321.

Harper, by contrast, has never sought services or challenged their quality. He is only claiming the right to avoid government intrusion on his person. Unlike *Youngberg v. Romeo*, which did not involve any claims under the right to privacy, and asked that the state provide better services for Romeo, this case involves an individual whose only claim is to be left alone. The professional judgment standard is meaningless in this context. It relates to the treatment that must be offered, not treatment that is refused.¹⁰⁸

¹⁰⁸ At issue in *Youngberg* was the use of soft arm restraints. 457 U.S. 307, at 310, 311 n.4. Their use was temporary and posed no threat of serious harm. Their effects are predictable and can be easily monitored. The intrusion upon the liberty interest ends when the restraints are removed. The intrusion presented by antipsychotic drugs is not comparable to that of temporary physical restraints. Physicians cannot predict the adverse effects drugs may have on a patient. Goodman & Gilman, *The Pharmacological Basis of*

The decision to accept or refuse treatment is not one for competing medical experts, but a deeply personal decision, made by the individual with myriad concerns, only some of which are medical. It is a decision best made by the courts which are best suited to consider those personal concerns.

The state does have a duty to provide persons in its custody with a certain minimally adequate level of medical and psychiatric care. But while a state may have an interest in accomplishing many different goals, in the context of prison regulations infringing constitutional rights, only legitimate penological interests are given special considerations. *Inmates of Monmouth County v. Lanzaro*, 834 F.2d 326, at 342 (3rd Cir. 1987), *cert. denied* 108 S.Ct. 1731 (1988) (State's interest in encouraging natural childbirth over abortion not a penological interest). The state has no duty under *Estelle v. Gamble*¹⁰⁹ nor any legitimate penological interest in forcing medical care on any competent¹¹⁰ inmate who does not wish to receive it, as long as

Therapeutics, at 172-74 (1975); Hollister, *Clinical Use of Psychotherapeutic Drugs*, 30-32 (1977). Antipsychotic drugs have serious and potentially irreversible side effects which are not easily detected. Additionally, soft arm restraints do not implicate First Amendment issues; antipsychotic medications do. But, as discussed in the text, the issue presented in this case does not concern the qualitative difference between the restraint imposed by drugs and by soft arm restraints. The difference between seeking appropriate treatment and not wanting any treatment at all is the difference between *Youngberg* and this case.

¹⁰⁹ 429 U.S. 97 (1976).

¹¹⁰ It is the competency of the adult Walter Harper that distinguishes this case from *Parham v. J.R.*, 442 U.S. 584 (1970). Of central importance to the decision in *Parham* was the fact that the liberty interest of the child therein is "inextricably linked with the parents' interest in and obligation for the welfare and health of the child, the private interest at stake is a combination of the child's and parents' concerns." *Id.* at 600. The Court relied on the "traditional presumption that the parents act in the best interests of their child

the inmate's condition is neither contagious nor life-threatening.

D. The Governmental Interest Does Not Overcome Harper's Liberty Interest.

The state's interest in maintaining a calm prison setting and its *parens patriae* interest in providing care to prison inmates are not sufficient to overcome Harper's liberty interest absent the due process which a judicial hearing would provide. Further, the fiscal and administrative burden that judicial hearings would entail is slight.

The state has an interest in running a secure and orderly prison facility. However, it cannot use forcible medical procedures to accomplish this goal. This court has repeatedly invalidated the use of medical procedures on an individual for state purposes, however worthy those state purposes might be in the abstract. For example, the Court held in *Rochin* that it "shocks the conscience" to pump a stomach for evidence.¹¹¹ Similarly it found too broad an invasion of privacy to countenance surgery to retrieve evidence in *Winston v. Lee*,¹¹² even though gathering evidence of criminal activity is generally a compelling government interest. These decisions did not minimize the importance of the state interest; they simply did not permit the use of highly intrusive medical interventions to accomplish the state purposes.

... " *Id.* at 604. Children have never been granted full rights in making their own medical treatment decisions; they are *de jure* incompetent and their parents have generally been accepted as having this authority. In addition, the Court in *Parham* was concerned that an adversarial hearing would be counterproductive because it would pit parent against child. *Id.* at 610. These considerations are not present in this case.

¹¹¹ 342 U.S. at 172.

¹¹² 470 U.S. 753 (1985).

Forcible medication cannot be justified solely by state goals of a calm prison setting. Prison authorities have long had troublesome inmates who are mentally ill,¹¹³ and they have developed many methods of external control without having to resort to internal control of a person by medication. To the extent that a prisoner's mental illness may cause unpredictable aggressive acts,¹¹⁴ the state interest is provided for to a large extent through the recognition that a mentally ill prisoner can be medicated without consent in emergency situations.¹¹⁵ Alternatives common in prison practice, including physical restraints and isolation, which are less intrusive than antipsychotic medications, exist to control episodic aggressive manifestations of mental illness.¹¹⁶

Beyond that the state's interest in maintaining order on a long-term basis by forcible use of sedating medication diminishes. "Absent an emergency . . . forcible medication with

¹¹³ SOC includes "behavior disorders," which arguably are not mental illnesses. Finding of Fact 2, Pet. B-2.

¹¹⁴ It should be recognized that there is a significant chance that a mentally ill prisoner's assaultiveness may not be due to his mental illness and therefore not treatable by medication.

¹¹⁵ *Bee v. Greaves*, 744 F.2d 1387, at 1395 (10th Cir. 1984), cert. denied 469 U.S. 1214 (1985); *People v. Medina*, 705 P.2d 961, at 974-75 (Colo. 1985); *Matter of Orr*, 531 N.E.2d 64, at 72 (Ill. App. 1988); *Rogers v. Commissioner of Mental Health*, 458 N.E.2d 308 (Mass. 1983); *Opinion of the Justices*, 465 A.2d 484, at 489 (N.H. 1983); *Rivers v. Katz*, 495 N.E.2d 337, at 343 (N.Y. 1986).

¹¹⁶ "[W]e are concerned with the state's obligation to maintain the security of its prisons rather than the medical efficacy of the proposed treatment. For purposes of prison security, the only feasible alternatives to involuntary medication may be physical restraints or isolation, but we are unable to conclude as a matter of law that these alternatives are 'more intrusive' than psychotropic drugs from the standpoint of a competent prisoner who does not want to be medicated." *In re Woodall*, No. A041054, 89 Daily Journal DAR 5193 at 5195, (Cal.App. April 18, 1989).

antipsychotic drugs is [not] reasonably related to the concededly legitimate goals of jail safety and security." *Bee v. Greaves*, 744 F.2d 1387, at 1395, (10th Cir. 1984) cert. denied 469 U.S. 1214 (1985).

Long term treatment¹¹⁷ with antipsychotic drugs cannot justify their involuntary administration. In *Dautremont v. Broadlawns Hospital*, 827 F.2d 291 (8th Cir. 1987),¹¹⁸ the court did authorize compelled medication based on a prediction of future dangerousness, a prediction based solely on the patient's previous activities outside the institutional setting. See 827 F.2d at 298.

However, forced medication based on a prediction of future harm is nothing more than preventive chemical restraint.¹¹⁹ The inherent potential for abuse under such a standard has been well documented in litigation and investigations. See Part III B. Courts, in rejecting the dangerousness standard have cited substantial evidence of the misuse of medication for purposes of patient management and staff convenience. *Rogers v. Commissioner*, 458 N.E.2d 308, at 319-22 (Mass. 1983).¹²⁰ In *Rogers*, the court restricted the police power authority to compel medication to situations requiring immediate action and even in these emergency situations, the court required the consideration of available less restrictive alternatives. *Id.*

¹¹⁷ Harper was involuntarily medicated for three and one-half years.

¹¹⁸ A 1983 civil rights suit brought by a court ordered civilly committed patient.

¹¹⁹ See *Rogers v. Commissioner*, 458 N.E.2d 308, at 319-22 (Mass. 1983).

¹²⁰ *Accord Davis v. Hubbard*, 506 F.Supp. 915, at 926 (N.D. Ohio 1980); *Large v. Superior Court*, 714 P.2d 399, at 409 (Ariz. 1980). Both cases rejected the dangerousness standard finding misuse of antipsychotic drugs.

Most psychiatrists agree that it is virtually impossible to accurately predict future violent behavior.¹²¹ Given this predictive uncertainty, the potential for abuse, and the availability of less intrusive measures to guard against future violence, the police power interest, when based on a dangerousness standard, is insufficiently compelling to justify the extensive intrusion into fundamental liberties that compelled medication presents.

If the medications cannot be used in order to maintain order within the prison, then the only possible justification for their use is to meet the state's interest in providing care to prison inmates. But even a legitimate interest in providing medical care to a competent prisoner cannot override his right to make his own treatment decisions, especially where the medications are dangerous and other alternatives exist to meet state objectives of running a calm prison setting.¹²²

The exercise of the *parens patriae* authority to force psychiatric treatment is premised on the need to help individuals who are incapable of making their own treatment decisions. *Addington v. Texas*, 44 U.S. 418, at 426 (1979). This "incapacity" limitation on government treatment authority is reflected in the common law doctrine of informed consent. The rationale behind this doctrine is the recognition that treatment decision-making is not solely a professional task. Although the health care provider may have more expertise regarding the benefits and risks of a particular medical intervention, the

¹²¹ See *Barefoot v. Estelle*, 463 U.S. 880, at 920 (1983) (Blackmun, J., dissenting) (quoting Brief for American Psychiatric Association as *Amicus Curiae*).

¹²² See *Turner v. Safley*, 432 U.S. 78, at ____, 96 L.Ed.2d 64, at 80 (1987) ("the existence of obvious, easy alternatives may be evidence that a regulation is not reasonable but is an exaggerated response to prison concerns.")

evaluation of this treatment information in light of subjective personal concerns is a right which belongs to the patient.¹²³

The values of bodily integrity and self-determination recognized by the informed consent doctrine are the same interests protected by the constitutional right to privacy.¹²⁴ "[T]he constitutional right to privacy . . . is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice."¹²⁵ Under both the common law and the constitutional right to privacy doctrine, the *sine qua non* of forced medical treatment based on *parens patriae* grounds is a determination that the patient is incapable of making his own treatment decisions. Without this finding of incompetency, the government's justification for its exercise of the *parens patriae* power is not sufficient; indeed, it no longer exists.¹²⁶

The government's interest in not granting Harper a judicial hearing appears to be its concern that these procedures would be unduly expensive, time-consuming and cumbersome. No

¹²³ See Part III C; Brooks, 8 Bull. Am. Acad. Psychiatry & Law at 190; Dickens, *Patients' Interests and Clients' Wishes: Physicians and Lawyers in Discord*, 15 Law, Medical & Health Care 110, at 114 (1987); Redlich & Mollica, *Overview: Ethical Issues in Contemporary Psychiatry*, 133 Am.J. Psychiatry 125, at 127 (1976); Rhoden, *The Right to Refuse Psychotropic Drugs*, 15 Harv. Civil Rights-Civil Liberties Law Rev. 363, at 383 (1980).

¹²⁴ E.g. *Davis v. Hubbard*, 506 F.2d 915, 931-33 (N.D. Ohio 1980); *Jarvis v. Levine*, 418 N.W.2d 139, at 149 (Minn. 1988).

¹²⁵ *Superintendent of Belchertown State School v. Saikewicz*, 307 N.E.2d 417, at 426 (Mass. 1977).

¹²⁶ See *Bee v. Greaves*, 774 F.2d 1387, at 1395 (10th Cir. 1984), cert. denied 469 U.S. 1214 (1985); *Project Release v. Prevost*, 722 F.2d 960, at 978 (2d Cir. 1983).

evidence has been advanced to support this contention. To the contrary, experience in the aftermath of court cases granting patients the right to refuse treatment shows that the result of granting the right to a court hearing is not more hearings but less forcible medication.¹²⁷ Psychiatrists are deterred from unsupportable medication decisions and negotiate more with their patients over the problems that the latter are having with the drugs. Ultimately, very few patients refuse drugs, and those that do often change their mind before going to court.¹²⁸ These findings appear to be holding true in the state of Washington. At SOC only three cases have been brought in court under the new Harper procedures.¹²⁹

There has been no legitimate concern advanced that a judicial hearing at the prison would impinge on prison security more than the administrative hearings that were held by SOC when Harper brought his suit in 1985. Although petitioners claim that additional security would be required if judges rather than the SOC panel were conducting the hearings at the prison, they advance no explanations as to why that would be the case.

¹²⁷ After the court's temporary restraining order in *Rogers v. Okin*, only 20 prolonged refusals were documented out of 1,000 patients over two years. Cole, "Patient's Rights vs. Doctor's Rights: Which Should Take Precedence?" in Doudera and Swazy, eds., *Refusing Treatment in Mental Institutions: Values in Conflict*, 65 (1982).

¹²⁸ Studies have also found judicial hearings themselves are therapeutic to the patients even when the result is adverse to them. The procedures established in the aftermath of *Davis v. Hubbard*, 506 F.Supp. 915 (N.D. Ohio 1980) were found to be "beneficial to patients because they believe they are being treated fairly. Patients who have unsuccessfully challenged their medication have generally been more cooperative after their hearings." Hickman, Resnick and Olson, *Right to Refuse Medication: An Interdisciplinary Proposal* 6 Mental and Physical Disability Law Reporter 130 (1982).

¹²⁹ Note, *Protecting the Inmate's Right to Refuse Antipsychotic Drugs*, 64 Washington Law Review 459, 461, n. 18, and 476 (1989).

In fact, judicial hearings cannot be so cumbersome as to be unworkable: the federal government chose to require court hearings prior to transfer from a prison to a mental hospital although *Vitek v. Jones* held that such a hearing was not required. 18 U.S.C. sec. 4245 (West 1988). With respect to the forcible administration of antipsychotic medications to prison inmates, most states follow the approach adopted by the Washington Supreme Court in this case: "the most frequent approach is to treat, without court order inmates who represent an emergency, and to seek court-ordered treatment for inmates who appear to be non-emergent and decisionally incapable [e.g. incompetent.]"¹³⁰

Finally, the state has an interest in insuring that, if Mr. Harper is treated with antipsychotic drugs, that that treatment is appropriate. In this sense, the state's interest in insuring that there is not an erroneous deprivation of Mr. Harper's liberty interest is congruent with Mr. Harper's interest. As discussed in Parts III B and C, *supra*, this risk is best minimized by resorting to a judicial process.

CONCLUSION

This Court should affirm the Washington Supreme Court finding that Walter Harper's liberty interest in refusing antipsychotic medications may be overcome only after a judicial hearing with its attendant due process safeguards including the right to counsel. The decision to deprive an individual of his rights to bodily security and to make his own medical decisions must, in our society, be made in the light of a courtroom.

¹³⁰ Raskin, *The Right to Refuse Psychotropic Medication in Correctional Settings*, 14 American Association of Psychiatry and Law Newsletter 18, 19 (April 1989) (Emphasis added).

The human body commands the greatest respect. It is the only thing in the world that is truly ours. When it is gone, we are gone.

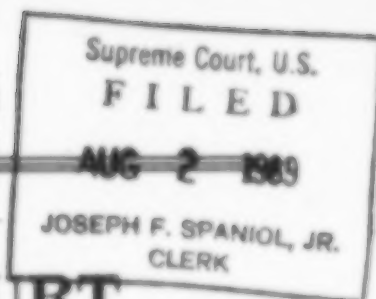
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REPLY BRIEF

NO. 88-599



IN THE
SUPREME COURT
OF THE
UNITED STATES

OCTOBER TERM, 1988

STATE OF WASHINGTON, et al.,

Petitioners,

v.

WALTER HARPER

Respondent,

**ON WRIT OF CERTIORARI TO
THE SUPREME COURT OF THE STATE OF
WASHINGTON**

REPLY BRIEF OF PETITIONERS

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INTRODUCTION AND SUMMARY OF ARGUMENT

The question before this Court is what process is required before antipsychotic medication can be administered involuntarily to a mentally ill prison inmate, and, more specifically, whether the medication decision must be made by a judge. Respondent Harper and his amici concede that there are circumstances in which involuntary administration is appropriate. Hence, the question presented is not whether a mentally ill inmate can ever be medicated involuntarily; it is what process is required before the medication may be administered.

Respondent and his amici have attempted to cloud the issue before this Court by mischaracterizing the facts of this case. The parade of horrors they have adduced is not relevant to this case. The record in this case demonstrates that Washington Special Offender Center Policy 600.300 provides adequate protection for whatever rights Mr. Harper may have in connection with the treatment he received.

The suggestion by Respondent and one of his amici that this matter is moot is amazing and disingenuous. Respondent is still incarcerated in the Washington prison system. While the appeal below was pending, Harper was reassigned to the Special Offender Center for thirteen (13) months, and involuntarily medicated during nine (9) of those months. It is reasonably likely that he will again be assigned to the Special Offender Center in the future; therefore, the applicability of Special Offender Center Policy 600.300 to him remains a live issue. Furthermore the Washington legislature's action in engrafting the decision below on to the state civil commitment statute does not moot the issue. Since Harper is not civilly committed, the legislation has no applicability to him.

The Court should cut through the horrific histrionics of Respondent and his amici, focus on the real issue as presented in the context of the record on this case, and reverse the decision of the Washington Supreme Court.

ARGUMENT

I. SPECIAL OFFENDER CENTER POLICY 600.300 PROVIDED ADEQUATE DUE PROCESS PROTECTION TO MR. HARPER.

A. The Parties Agree That Involuntary Medication For Mentally Ill Inmates Is Appropriate Under Some Circumstances. The Issue Before The Court Is Not Whether Antipsychotic Medications Should Be Used, But What Process Requirements Exist When The State, Rather Than The Patient, Makes The Decision.

Given the passion with which Respondent and his amici have advanced their various positions, it is significant that there are certain core propositions upon which all the parties agree:

1. Antipsychotic medications can provide beneficial treatment for many mentally ill persons. See Brief of Respondent, pp. 21-23; Amicus Curiae Brief of the American Psychological Association in Support of Respondent, p. 10. ("For some patients, these drugs may be helpful--even essential--in restoring mental function.")
2. There is the possibility of side effects associated with treatment with antipsychotic medications. Brief of Petitioners, pp. 20-24; Brief of Respondent and his amici, *passim*.
3. There are circumstances when the involuntary administration of antipsychotic medication is appropriate. Brief of Respondent, p. 44 ("[A] mentally ill prisoner can be medicated without consent in an emergency situation"); Amicus Curiae Brief

of the American Psychological Association in Support of Respondent, p. 21 ("[W]e support the principle that involuntary medication can be administered if truly necessary in order to prevent instant harm to inmates or staff.")¹

Thus, the question before the Court in the instant case is not *whether* involuntary medication of mentally ill inmates should take place, but rather what process is "due" under the Fourteenth Amendment before such medication occurs.

Respondent argues that the issue before the Court "is one of the prisoner's competence to refuse medication." Brief of Respondent, p. 36. That is a misstatement.

The decision below did not involve competence. Rather, as the Washington Supreme Court stated:

[W]e hold that a judicial hearing must be held to determine *whether* the state can treat a prisoner with antipsychotic drugs against his will. A court may *order* imposition of antipsychotic drug treatment upon a nonconsenting prisoner when the State proves (1) a compelling state interest to administer antipsychotic drugs, and (2) the administration of the drugs is both necessary and effective for furthering that interest. * * *

Pet. A-10, 11 (footnotes and citation omitted, emphasis added).

Under the Washington Supreme Court's decision, a court could order involuntary medication if the requisite showing is made, even though the inmate refusing the medication is competent.

¹ The Washington Supreme Court in its opinion below did not differentiate between emergency and non-emergency situations. This raises the specter that under that ruling a judicial hearing is required even in an emergency. Reacting to the *Harper* decision, the Washington legislature passed legislation attempting to deal with emergency situations in the civil commitment context. This legislation is discussed in more detail in Part III, *infra*.

The decision below requires that a judge asked to order involuntary medication "consider the patients' desires," and make a substituted judgment of what those desires might be for an inmate who "appears unable to understand fully" the proceedings. Pet. A-11, quoting from *In re Schuoler*, 106 Wn.2d 500, 507, 723 P.2d 1103 (1986).

However, the judge is not called upon to decide competence. Rather, it is the ultimate treatment decision -- "whether the state can treat a prisoner with antipsychotic drugs against his will," Pet. A-10 -- that the judge is called upon to make.³

B. Special Offender Center Policy 600.300 Provides Appropriate Due Process Protections Which Were Observed As To Respondent Harper.

Under Special Offender Center Policy 600.300, involuntary administration of antipsychotic medication is limited to those inmates assigned to that facility:

1. who are suffering from a mental disorder; and
2. who are either gravely disabled or present a likelihood of serious harm to themselves or others as a result of that mental disorder; and
3. for whom the medication has been prescribed or approved by a psychiatrist.

The hearing process required by the policy provides a safeguard to assure that involuntary medication in fact takes place only if all these circumstances exist.

³ Interestingly, Respondent and his amici are not of one mind on who should make the treatment decision. Respondent has consistently argued--and the court below held--that only a judge could order involuntary medication. Cf. Amicus Curiae Brief of the American Psychological Association in Support of Respondent, p. 3 (Involuntary medication "requires a hearing before a truly independent, unbiased decision maker--either a court or a properly constituted administrative body").

It is undisputed in this case that the circumstances contemplated by the policy existed:

1. Harper, a felon sentenced to the Department of Corrections and assigned to the Special Offender Center. Findings of Fact 4 and 5, Pet. B-4, 5.
2. Harper was suffering from a mental disorder. Finding of Fact 11, Pet. B-8.
3. As a result of his mental disorder, Harper presented a likelihood of serious harm to others. *Id.*
4. The medication which was administered to Harper had been prescribed for him by a psychiatrist, Dr. Petrich, one of the Defendants below. Findings of Fact 5 and 6, Pet. B-5.

The trial court also made a finding--not disputed on appeal--that Mr. Harper's medical care was appropriate. Findings of Fact 12, Pet. B-8.

Respondent argues that the absence of a trial court finding that "the medications were prescribed to benefit or treat Harper, or that they did have that effect * * * raises a strong inference that the drugs were used as punishment for disciplinary infractions." Brief of Respondent, p. 27. This is unmitigated sophistry. In the first place, if Respondent had had any evidence to that effect, he should have introduced it at trial, asked the trial court to make such a finding, or at least raised the issue before the Washington Supreme Court. He did none of these.

Secondly, for Dr. Petrich to have prescribed medications for "other than legitimate therapeutic purposes" would be unprofessional conduct in violation of Wash. Rev. Code § 18.30.180(6). The trial court's finding that Harper's medical care was appropriate rejects any such suggestion. Finding of Fact 12, Pet. B-8. The findings cited above constitute an implicit--if not explicit--finding

that the medications were prescribed for therapeutic reasons and administered appropriately.

Respondent and his amici, by a selectively literal reading of Finding of Fact 7, Pet. B-6, have also attempted to mislead this Court into believing that the hearings conducted with respect to Mr. Harper were not fairly conducted. See Brief of Respondent, p. 30.

This argument is based on an overly literal reading of the following portion of Finding of Fact 7:

* * * prior to the hearing, the hearing committee would consult with the staff outside the presence of the plaintiff for the purpose of ascertaining whether the requirements of the policy had been met and what the position of the staff *would* be at the hearing. Special Offender Center staff members would summarize (sic) their position for the hearing committee by briefly presenting their reasons as to why the plaintiff was dangerous and why his condition was a product of a mental disorder.

Finding of Fact 7, Pet. B-6. (Emphasis added.)

From this language, Respondent would have the Court believe that Mr. Harper was never told the basis for the recommendation of his treating psychiatrist and thus deprived of a "meaningful" opportunity to cross examine the psychiatrist or refute the recommendation. Brief of Respondent, p. 30.

Such an interpretation of this finding ignores the sentence which immediately follows the portion of Finding of Fact 7 quoted above:

Mr. Harper would then be brought into the hearing *which would take place in accordance with the policy.*

Finding of Fact 7, Pet. B-6. (Emphasis added.) It is undisputed that the policy required that Mr. Harper have at least twenty-four (24) hours notice of the hearing as well as

notice of the tentative diagnosis, factual basis for the diagnosis, and the basis on which medical treatment is necessary.

Finding of Fact, Pet. B-3. Further,

[a]t the hearing * * * the institution is required to present its evidence [and] the inmate may present his own witnesses and cross-examine staff witnesses.

Id.

The statement in Finding of Fact 7 that the hearings "would take place in accordance with the hearing" necessarily includes a finding that Mr. Harper was accorded the rights provided to him under policy 600.300. Moreover, had Respondent truly believed otherwise, he would have either proposed findings to that effect or raised this argument before the Washington Supreme Court. He did neither.

Significantly, Respondent does not argue that he was prejudiced by the holding of a brief pre-hearing conference at which the hearing committee verified compliance with procedural requirements³ and received a brief summary of the staff's anticipated evidence.⁴

Respondent's attempt to have this Court believe that Mr. Harper's hearings were not conducted in accordance with Special Offender Center Policy 600.300, including all of the rights conferred by that policy, is simply contrary to the record before this Court.

³ There would be no point in convening a full hearing if the procedural requirements had not been satisfied.

⁴ The use of the verb "would" in Finding of Fact 7 confirms that the pre-hearing briefing was not *the* presentation of the staff's evidence, but merely a summary of what was expected to be presented when the hearing itself was actually convened.

II. RESPONDENT AND HIS AMICI HAVE TOTALLY FAILED TO ADDUCE ANY APPLICABLE CASE LAW TO SUPPORT THEIR POSITIONS.

A. Respondent's Reliance on *Winston v. Lee* is misplaced.

Respondent argues that his claimed right to reject treatment is analogous to that recognized by this Court in *Winston v. Lee*, 470 U.S. 753 (1985). In that case the Court upheld a lower court injunction prohibiting a court ordered surgery to remove a bullet from the body of a suspect in an armed robbery investigation. The state argued that the bullet could provide evidence of the guilt or innocence of the accused.

This Court, citing the Fourth Amendment's proscription against unreasonable search and seizure, concluded that the state had "failed to demonstrate that it would be 'reasonable' under the terms of the Fourth Amendment to search for evidence of this crime by means of the contemplated surgery." *Winston* at 767.

Respondent's attempted analogy to *Winston* is not apt. The parties' interests in *Winston* were quite different than those involved in the instant case. Mr. Harper is a convicted felon serving a sentence in a state prison, whereas Mr. Lee had not yet been convicted of anything. The state's interest here is in providing therapeutic medical treatment to a mentally ill prisoner.⁵ In *Winston*, the state's interest was in acquiring evidence against a person at that time presumed to be innocent.

In addition, *Winston* involved the reasonableness of a search, under the Fourth Amendment, which protects "privacy interests." *Winston*, at 759 (citation omitted).

The central issue in this case--what process is due when the state makes the decision to medicate over the inmate's objection--arises under the Fourteenth Amend-

⁵ Indeed, the State has an obligation to provide appropriate care, including psychiatric care. See *Estelle v. Gamble*, 429 U.S. 97 (1976); *Bowring v. Godwin*, 551 F.2d 44 (4th Cir. 1977).

ment, which is designed "to minimize the risk of erroneous decisions." *Addington v. Texas*, 441 U.S. 418, 426 (1979).⁶ The decision below rested "on due process grounds." Pet. A-4, n.2.

B. This Court's Decision In *Youngberg v. Romeo* Requires Reversal Of The Decision Below.

Respondent's attempts to distinguish *Youngberg v. Romeo*, 457 U.S. 307 (1982), the leading case from this Court addressing the issue of what due process requires in a mental health treatment context, are likewise ineffective. Respondent claims that *Youngberg* is inapplicable because Mr. Romeo "was seeking appropriate treatment, [and] Mr. Harper is not." Brief of Respondent, p. 40. This is a mischaracterization of *Youngberg*, which admittedly involved claims for both safe conditions and training, but also included Romeo's assertion of "a right to freedom from bodily restraint." *Youngberg* at 317.

In resolving this assertion, the Court recognized that "Romeo [had] liberty interests in safety and freedom from bodily restraint," *Youngberg* at 320, but also recognized that this did not end its inquiry:

In determining whether a substantive right protected by the Due Process Clause has been violated, it is necessary to balance 'the liberty of the individual' and 'the demands of an organized society'.

Youngberg at 321 (citations omitted). Further, the Court noted that it had "taken a similar approach in deciding procedural due process challenges" to state infringements on individual liberty in the context of civil commitment for mental health treatment, and had concluded that procedural due process did not mandate an adversarial

⁶ Although the Washington Supreme Court did not specifically state that it was the Federal Constitution upon which it based its holding, rather than the state constitution, such a conclusion is necessarily implied, since the action before it was brought under 42 U.S.C. § 1983.

hearing. *Youngberg* at 321-322, citing *Parham v. J.R.*, 442 U.S. 584 (1979).

The *Youngberg* Court concluded that the proper standard had been correctly enunciated by Chief Judge Seitz of the Court of Appeals for the Third Circuit in his concurring opinion in *Romeo v. Youngberg*, 644 F.2d 147 (3rd Cir. 1980).

We think the standard articulated by Chief Judge Seitz affords the necessary guidance and reflects the proper balance between the legitimate interests of the State and the rights of the involuntarily committed to reasonable conditions of safety and freedom from unreasonable restraints. He would have held that 'the Constitution only requires that the courts make certain that professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made.' 644 F.2d at 178.

Youngberg at 322.⁷

The decision of the Washington Supreme Court below flies in the face of this Court's decision in *Youngberg*. The Washington Supreme Court below held that:

A court may order imposition of antipsychotic drug treatment of a nonconsenting prisoner when the State proves (1) a compelling state interest to administer antipsychotic drugs, and (2) the administration of the drugs is both necessary and effective for furthering that interest.

⁷ There is no doubt that *Youngberg* is applicable to a claim to be free from the involuntary treatment with antipsychotic medication. Precisely such a claim was before this Court when it remanded a case in light of *Youngberg*. See, *Rennie v. Klein*, 458 U.S. 1119 (1982), on remand 720 F.2d 266 (3rd Cir. 1983).

Pet. A-10. (Footnote and citation omitted.) Thus, under the decision below, courts are required to "specify which of several professionally acceptable choices should [be] made"--precisely what this Court in *Youngberg* held to be "not appropriate."

C. The Decision Below Is Inconsistent With This Court's Decision In *Vitek v. Jones*.

Harper argues that he has a liberty interest in being free of the unwanted administration of antipsychotic medication. Brief of Respondent, pp. 14-15. This assertion relies in part on *Vitek v. Jones*, 445 U.S. 480 (1980). *Id.* at 13-14. However, since Respondent Harper argues that a judicial hearing must be held prior to the involuntary administration of antipsychotic drugs, by necessity he also argues that the due process protections established in *Vitek* are not sufficient in the instant case.

The *Vitek* case involved the transfer--pursuant to a state statute--of a prisoner to a mental hospital for involuntary psychiatric treatment. That treatment included chemotherapy and the involuntary administration of antipsychotic drugs, specifically Thorazine.⁸ See, Brief Amicus Curiae of the Coalition for the Fundamental Rights and Equality of Ex-Patients in Support of Respondent, p. 9, n. 7. See also, *Miller v. Vitek*, 437 F. Supp. 569, 571, n. 8 (D. Neb. 1977).

The *Vitek* court specifically analyzed the consequences of a commitment to a mental hospital for an ordinary citizen as well as the deprivation of the liberty interest of the convicted felon at issue in that case. *Vitek* at 491-5. The *Vitek* court concluded that: "a convicted felon also is entitled to the benefit of procedures appropriate in the circumstances before he is found to have a mental disease and transferred to a mental hospital." *Vitek* at 494 (emphasis added).

⁸ Thorazine, a brand name, is one of the medications specifically mentioned by the Washington Supreme Court in describing the scope of its holding. Pet. A-4, n. 3.

This Court in *Vitek* approved an administrative process very similar to Special Offender Center Policy 600.300 as adequate procedural protection for the liberty interest there involved.⁹ Combining the holding in the decision below with the holding in *Vitek* would lead to the following result: while an administrative proceeding provides adequate protection as to a decision to transfer an inmate to a mental hospital for mandatory treatment, a judicial decision is an additional necessary requirement before the treatment can be implemented. This result would be anomalous if not absurd.

The *Vitek* court recognized that a convicted felon "retained a residuum of liberty," *Vitek* at 492, and that freedom from transfer to a mental hospital for mandatory treatment was within its scope. It is medical treatment in the prison setting—not transfer to a mental hospital—which is at issue here. Given that the state has obligation to provide treatment to mentally ill inmates,¹⁰ to argue that a higher standard of procedure is required for the decision to treat than for a decision to transfer for treatment is both illogical and inconsistent with this Court's holding in *Vitek*.

⁹ As both the trial court and the Washington Supreme Court noted, Special Offender Center Policy 600.300 was adopted at least in part in reliance on the *Vitek* decision. See, Finding of Fact 3, Pet. B-3; Pet. A-12. This is not to say that the procedures embodied in the policy are the constitutionally mandated minimum. Indeed, under *Youngberg*, any process which assures that professional judgment is in fact exercised suffices. See Part III B, *supra*, p. ___. Petitioners submit that the procedures in Policy 600.300 meet or exceed any procedural requirements of the United States Constitution.

¹⁰ See p. ___, n. ___, *supra*.

III. THIS CASE IS NOT MOOT.

Respondent and one of his amici argue that intervening events have rendered this case moot. Brief of Respondent, pp. 7-9; Brief Amicus Curiae of the Coalition for the Fundamental Rights and Equality of Ex-Patients in Support of Respondent, pp. 5-8. This claim of mootness requires a further examination of *Vitek*.

Respondent's mootness argument rests on two prongs. First, Harper asserts that since he is not currently incarcerated at the Special Offender Center, the claims for declaratory and injunctive relief no longer present a "live controversy between Harper and petitioners." Brief of Respondent, p. 7. Indeed, Mr. Harper was transferred from the Special Offender Center to the Washington State Penitentiary in July, 1986. Finding of Fact 8, Pet. B-7.¹¹ However, Mr. Harper was transferred to the Special Offender Center in April of 1987 and remained there until May of 1988. He was treated with involuntary medication while at the Special Offender Center from September, 1987 to May, 1988.

The salient point is that Mr. Harper remains incarcerated in the Washington prison system. Given his history of mental illness and violent manifestations of that illness, it is likely that he will again be assigned to the Special Offender Center and again subject to involuntary medication under Policy 600.300.

In this posture, the mootness claim raised by Respondent here is virtually indistinguishable from the mootness issue addressed by the Court in *Vitek*, *supra*. There, the plaintiff who sought an injunction against transfer from

¹¹ If, as Respondent suggests, Harper's injunctive and declaratory relief claims are now moot, they were likewise moot at the time of trial in March, 1987. Curiously, Respondent made no such mootness argument to the trial court.

a prison to a non-prison mental hospital had been paroled during the pendency of the litigation. He subsequently violated his parole and was again incarcerated, but there was no indication that transfer to the mental hospital was being considered when the matter came before this Court.

The Court agreed with the parties in *Vitek* that the case was not moot, based primarily on the plaintiff's "history of mental illness" and the fact that the plaintiff there had been returned to the prison system. *Vitek* at 487.

The only distinction between *Vitek* and this case is that in *Vitek* the district court¹² had in fact issued an injunction whereas in the instant case, the Washington Supreme Court has merely declared what it perceives the law to be, and remanded the matter to the trial court for further proceedings. Pet. A-12-13.

The practical reality, however, is that the decision of the Washington Supreme Court operates as both the declaratory and injunctive relief which Respondent sought. While Petitioners did not incur liability for monetary damages, they would be at risk of such liability for future implementation of Special Offender Center Policy 600.300, since the law is now "clearly established" if the decision below is allowed to stand.¹³

Boiled to its essence, this prong of Respondent's mootness argument is that since he got most of what he wanted from the Washington Supreme Court, this Court should "leave well enough alone" and decline to exercise its jurisdiction. Such an argument lacks both grace and substance--it should be given the same short shrift as in *Vitek* and rejected.

¹² *Vitek* was a direct appeal from a decision of the three judge district court convened pursuant to 28 U.S.C. § 2281, now repealed. See *Vitek*, 445 U.S. 484-5, n. 4.

¹³ See *Harlow v. Fitzgerald*, 457 U.S. 800 (1982); Pet. A-11-12.

The second prong of Respondent's mootness argument is based on amendments made to the Washington civil commitment statute in the wake of the *Harper* decision below. See Wash. Rev. Code 71.05, as amended by Chapter 120, Washington Laws of 1989. This prong is equally unsupportable.

Washington's Involuntary Treatment Act does not apply to Mr. Harper--he is an incarcerated felon, not a civil committee. The Special Offender Center is a prison not an evaluation and treatment facility. See Wash. Rev. Code § 71.05.020(16) ("[N]o correctional institution or facility, or jail, shall be an evaluation and treatment facility within the meaning of this chapter."). The statutory rights accorded by Wash. Rev. Code § 71.05.370 to persons "detained * * * pursuant to this chapter" (i.e. Chapter 71.05 Wash. Rev. Code) simply do not apply to Mr. Harper since he is detained *not* pursuant to the Involuntary Treatment Act but pursuant to his felony criminal conviction.

Moreover, close examination of these legislative amendments demonstrates that they are nothing more than a reaction to the *Harper* decision. The amendments are twofold. They engraft onto the state's civil involuntary treatment act processes a mechanism for conducting the judicial hearings mandated by the decision below prior to involuntary medication. Secondly, they purport to authorize involuntary administration of antipsychotic medications without a court order in "emergency" situations.¹⁴

Given that these amendments were adopted in the first legislative session after the *Harper* decision, and so closely track with that decision and the *Schuoler* decision¹⁵ upon which it rested, there is little doubt that the legislation was passed in reaction to the decision below.

¹⁴ As noted above, whether these legislative enactments will stand given the broad sweep of the decision below, which makes no allowance for emergency situations, may be in doubt. *Supra*, p. __, n. __.

¹⁵ *In re Schuoler*, 106 Wn.2d 500, 723 P.2d 1103 (1986).

Thus, again Respondent and his amicus are using a mootness argument in an attempt to preserve a status quo which is, because of the decision below, to their liking--not because the dispute between these parties over the central issue of this case has become any less lively.

Respondent's mootness arguments are without merit. This Court should hear and resolve this case on its merits.

IV. THE EMOTIONAL ARGUMENTS ADVANCED BY RESPONDENT AND AMICI DISREGARD THE EFFECTS OF NOT TREATING MENTAL ILLNESS AND ARE NOT BASED ON THE RECORD OF THIS CASE.

The theme that runs throughout the arguments advanced by Respondent and his amici goes like this: (1) antipsychotic medications are bad, because of the possible side effects associated with their usage in treatment; (2) the use of such medications should be as severely limited as possible; (3) requiring a judge to decide when such medications are to be used will impose a severe restriction on the use of these medications; (4) therefore, requiring a judicial hearing prior to involuntary administration is good because it will mean that fewer people will be subjected to the risk of side effects associated with the use of such medications.

Yet Respondent acknowledges that antipsychotic medication provides beneficial treatment for many mentally ill people. Brief of Respondent, p. 22. Erecting barriers to restrict the use of medically prescribed medications will prevent the possibility of benefits as much as the possibility of side effects.

No one can, or does, dispute the possibility of side effects associated with the use of antipsychotic medications. However, that possibility cannot be evaluated in the abstract. Rather it must be balanced against what will happen to the inmate patient if he or she does not

receive the medication prescribed by the treating physician.

Respondent has pointed to no study which documents any therapeutic benefits of physical restraints, assaultive behavior, self-abuse and effacement, or any of the other destructive activities often associated with untreated mental illness. Nor has Respondent attempted to weigh the risks associated with such activities against the risks inherent in following medically accepted pharmacological therapies.

Respondent's Brief and those of most of his amici, are replete with sweeping generalizations about the use of antipsychotic medications. Words such as "misuse", "haphazard" and "overprescribed" appear throughout.

None of these generalizations are based on or supported by the record of *this* case. Nor are they supported by a factual showing arising in a context involving a hearing process like that required by Special Offender Center Policy 600.300 and used to limit the involuntary administration of antipsychotic medications.

One of Respondent's amici--the New Jersey Department of Public Advocate--has filed a brief which purports to describe the involuntary medication review procedure which was upheld after remand by this Court in light of *Youngberg* in *Rennie v. Klein*, 720 F.2d 266 (3rd Cir. 1983). Brief of the New Jersey Department of Public Advocate as *Amicus Curiae* in Support of Respondent, p. 46.¹⁸ The New Jersey amicus characterizes its procedure as "similar" to Special Offender Center Policy 600.300. *Id.*, p. 48. To the contrary, the New Jersey procedure is less rigorous than that used at the Special Offender Center. The New Jersey procedure apparently requires

¹⁸ The propriety of this so-called brief is questionable, since it consists mostly of unsworn testimony apparently aimed at relitigating a case its authors did not win before this Court, rather than legal arguments supporting Respondent's position in this case. Cf. Supreme Court Rules 34.5, 34.6.

only a review by the treatment team, not an independent multi-discipline panel whose members are *not* currently part of the treatment team, as is the case under Special Offender Center Policy 600.300. Further, decisions under the New Jersey procedure do not appear to be judicially reviewable, whereas those under the Special Offender Center Policy are. Conclusion of Law 2, Pet. B-8.

Moreover, it should be noted that the tragic events described by this amicus curiae arose not from the decision to medicate--which is what is at issue here--but from the actual administration and monitoring which took place thereafter. No one has suggested--seriously or otherwise--that in addition to making the decision to medicate, as required by the decision below, a judge should also perform the administration and monitoring of the medications, thus having a judicial decision maker would not necessarily have prevented those tragedies.¹⁷

One of the major criticism of Special Offender Center Policy 600.300 lodged by Respondent is that [t]wo members of the panel were not licensed to prescribe antipsychotic medication and therefore would be unlikely to discern the inappropriate use thereof. Brief of Respondent, p. 29. Ironically, Respondent argues the question of medication should be decided by a judge--also unlicensed to prescribe medication and therefore presumably equally undiscerning, at least under Respondent's analysis.

¹⁷ The New Jersey amicus ascribes two patient deaths to neuroleptic malignant syndrome--the largest--and most recent--study of neuroleptic malignant syndrome concluded that "with good supportive care in hospital, the illness need not be fatal and in fact has a good prognosis." Rosebush & Stewart, *A Prospective Analysis of 24 Episodes of Neuroleptic Malignant Syndrome*, 146 *The American Journal of Psychiatry*, Number 6, p. 724 (June, 1989).

Indeed, if there is any lesson to be learned from all the citations to all of the medical literature in all the briefs--parties and amici alike--it is that the decision to medicate involves the exercise of medical judgment. No doubt it is complicated by the relative risks and benefits of using a particular medication with a particular patient--but in the final analysis, it is a medical--not legal--decision which must be made.

CONCLUSION

Special Offender Center Policy 600.300 provides an adversarial hearing prior to the involuntary administration of antipsychotic medications, thus assuring that the decision to medicate is based on the exercise of professional medical judgment. The policy provides adequate protection to any right an inmate may have to refuse medically prescribed treatment.

For the reasons set forth herein and in the Brief of Petitioners, the decision of the Washington Supreme Court below should be reversed, with direction to reinstate the decision of the trial court.

DATED this 31st day of July, 1989.

Respectfully submitted

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AMICUS CURIAE

BRIEF

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No. 88-599

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In the Supreme Court of the United States

OCTOBER TERM, 1988

STATE OF WASHINGTON, ET AL., PETITIONERS

v.

WALTER HARPER

ON WRIT OF CERTIORARI TO
THE SUPREME COURT OF WASHINGTON

**BRIEF FOR THE UNITED STATES
AS AMICUS CURIAE SUPPORTING PETITIONERS**

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32 PP

QUESTION PRESENTED

Whether a mentally ill and dangerous prisoner has a due process right to refuse antipsychotic medication in the absence of findings, made after an adversarial judicial hearing, that the prisoner is incapable of deciding for himself whether to take the medication and that the medication is in his best interest.

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In the Supreme Court of the United States

OCTOBER TERM, 1988

No. 88-599

STATE OF WASHINGTON, ET AL., PETITIONERS

v.

WALTER HARPER

ON WRIT OF CERTIORARI TO
THE SUPREME COURT OF WASHINGTON

**BRIEF FOR THE UNITED STATES
AS AMICUS CURIAE SUPPORTING PETITIONERS**

INTEREST OF THE UNITED STATES

The United States has an interest in this case for two reasons. First, the federal Bureau of Prisons operates four facilities for the treatment of persons charged with or convicted of a crime who suffer from a mental disease or defect. Psychiatrists at those facilities are confronted with the question whether to administer antipsychotic medication against an inmate's will. That problem has produced litigation to which the United States is a party. See, e.g., *United States v. Charters*, 863 F.2d 302 (4th Cir. 1988) (en banc), petition for cert. pending, No. 88-6525; *United States v. Leatherman*, 580 F. Supp. 977 (D.D.C. 1983), appeal dismissed, 729 F.2d 863 (D.C. Cir. 1984) (Table). Second, the United States has the responsibility under the Civil Rights of Institutionalized Persons Act, 42 U.S.C. 1997-1997j, to bring suit to protect the constitutional rights of persons in mental institutions, and the United States has participated in cases involving the involuntary use of antipsychotic drugs on such persons. E.g., *R.A.J. v. Miller*, 590 F. Supp. 1319 (N.D.

Tex. 1984); *Davis v. Hubbard*, 506 F. Supp. 915 (N.D. Ohio 1980). Thus, the federal government has an interest both in ensuring that physicians can prescribe antipsychotic medication when it is appropriate to do so, and in seeing that there are adequate safeguards to protect the rights of patients against the improper use of such medication.

STATEMENT

1. Antipsychotic drugs have been used for the past 35 years to treat various forms of psychosis. Antipsychotic drugs cannot cure mental illness, but they are recognized to be an effective means of treating the symptoms of psychoses such as schizophrenia. They organize a psychotic's cognitive processes, eliminate or suppress the more florid manifestations of his illness (e.g., hallucinations and delusions), and counteract assaultiveness, severe excitement, or withdrawal. Those anti-symptomatic effects are themselves therapeutic, and they also enable the psychotic to profit from other forms of treatment, such as psychotherapy, to adjust socially within and outside a structured hospital environment, and perhaps ultimately to avoid a lifetime of institutionalization.¹

¹ See, e.g., American Psychiatric Ass'n, *Task Force Report 18: Tardive Dyskinesia* 123, 137-153 (1979) [hereinafter *APA Task Force*]; Nat'l Inst. of Mental Health, *Phenothiazine Treatment in Acute Schizophrenia*, 10 *Archives Gen. Psychiatry* 246 (1964); Berger, *Medical Treatment of Mental Illness*, 200 *Science* 974 (1978); Davis, *Overview: Maintenance Therapy in Psychiatry: I. Schizophrenia*, 132 *Am. J. Psychiatry* 1237 (1975); Hogarty et al., *Drug and Sociosotherapy in the Aftercare of Schizophrenic Patients*, 31 *Archives Gen. Psychiatry* 603 (1974); Jeste & Wyatt, *In Search of Treatment for Tardive Dyskinesia: Review of the Literature*, 5 *Schizophrenia Bull.* 25 (1979); Jeste & Wyatt, *Therapeutic Strategies Against Tardive Dyskinesia*, 39 *Archives Gen. Psychiatry* 803 (1982); Kane, *Treatment of Schizophrenia*, 13 *Schizophrenia Bull.* 133, 142 (1987); Kessler & Waletzky, *Clinical Use of the Antipsychotics*, 138 *Am. J. Psychiatry* 202 (1981); Meadow et al., *Effects of Phenothiazines on Anxiety and Cognition in Schizophrenia*, 36 *Diseases of the Nervous System* 203 (1975).

For those reasons, there is widespread recognition in the psychiatric community that, despite the potential risks from the use of antipsychotic medication, such drugs are an appropriate form of treatment for certain seriously ill patients. In fact, some experts in the field have expressed the view that antipsychotic drugs "remain the primary modality in the treatment of an acute episode or an acute exacerbation of a schizophrenic illness," Kane, *Treatment of Schizophrenia*, 13 *Schizophrenia Bull.* 133, 134 (1987); and that "the use of available antipsychotic agents continues to be the cornerstone of management for these serious and disabling mental illnesses," Baldessarini & Lipinski, *Risks of Antipsychotic Drugs Overemphasized*, 305 *N.E.J. Med.* 588, 588 (1981).²

While antipsychotic drugs have widely acknowledged benefits, it is also recognized that they can cause a variety of side effects.³ Most potential side effects are mild, they disappear when the medication is discontinued, and they can be treated with other drugs.⁴ Some of the side effects, however, can be

² See also Jeste & Wyatt, 5 *Schizophrenia Bull.* at 25 ("Pharmacotherapy is widely recognized as the single most effective treatment for schizophrenia. For most patients, it offers the advantages of higher reliability, greater effectiveness, easier accessibility, and fewer hazards than any other known treatment. Furthermore, the introduction of neuroleptics in the mid-1950's is believed to have played a major role in the ensuing dramatic declines in the number of hospitalized schizophrenics.").

³ See generally *APA Task Force* 13-19; Ayd, *A Survey of Drug-Induced Extrapyramidal Reactions*, 175 *J.A.M.A.* 1054 (1961); Baldessarini, *Clinical and Epidemiologic Aspects of Tardive Dyskinesia*, 46 *J. Clinical Psychiatry* 8 (1985); Gutheil & Appelbaum, "Mind Control," "Synthetic Sanity," "Artificial Competence," and *Genuine Confusion: Legally Relevant Effects of Anti-psychotic Medication*, 12 *Hofstra L. Rev.* 77, 105-117 (1983); Kennedy et al., *Extrapyramidal Disorders After Prolonged Phenothiazine Therapy*, 118 *Brit. J. Psychiatry* 509 (1971).

⁴ One category of side effects, called extrapyramidal symptoms, includes drowsiness or fatigue (akinesia); the inability to sit still or an irresistible desire to walk or tap the feet (akathisia); acute and painful muscle spasms (dystonia); and conditions resembling Parkinson's disease, such as tremors, rigidity, or repeatedly moving one or both hands. Those side effects disappear if medication is discontinued, and they can be treated with other drugs. A second

serious. The most troublesome potential side effect is tardive dyskinesia.⁵ Tardive dyskinesia is characterized by involuntary muscular, tic-like actions, such as continuously chewing, smacking the lips, contorting the face, or moving the hands and legs. It is painless, but obviously can be very distressing. Tardive dyskinesia ordinarily appears only after prolonged drug treatment (months to years),⁶ and may be mild or severe. It is impossible to predict its occurrence, but some estimates are that approximately 20 per cent of persons receiving long-term treatment may be affected.⁷ Some forms of dyskinesia may be reversi-

category of side effects includes dizziness, dry mouth and throat, blurred vision, weight gain, cardiovascular changes, low blood pressure, and depression. Those side effects are also temporary and treatable. R. Baldessarini, *Chemotherapy in Psychiatry* 43-44 (1977); *APA Task Force* 13-17; Gutheil & Appelbaum, 12 Hofstra L. Rev. at 108.

⁵ Another hazardous side effect is neuroleptic malignant syndrome, which is characterized by rigidity, dance-like movements, and alterations in consciousness. It is quite rare, but can be fatal. It can be prevented by discontinuing medication, and it can be treated with other drugs. Addonizio *et al.*, *Symptoms of Neuroleptic Malignant Syndrome in 82 Consecutive Inpatients*, 143 Am. J. Psychiatry 1587 (1986); Pope *et al.*, *Frequency and Presentation of Neuroleptic Malignant Syndrome in a Large Psychiatric Hospital*, 143 Am. J. Psychiatry 1227 (1986).

⁶ Jeste & Wyatt, *Changing Epidemiology of Tardive Dyskinesia: An Overview*, 138 Am. J. Psychiatry 297, 297 (1981); Kessler & Waletzky, *Clinical Use of the Antipsychotics*, 138 Am. J. Psychiatry at 205; Quitkin *et al.*, *Tardive Dyskinesia: Are First Signs Reversible?*, 134 Am. J. Psychiatry 84 (1977). Tardive dyskinesia, however, has also been reported after several weeks or months of medication.

⁷ Reports of the incidence of tardive dyskinesia have varied from 0.5% to 65%. See, e.g., *APA Task Force* 43-44; Crane, *Persistent Dyskinesia*, 122 Brit. J. Psychiatry 395 (1973). The wide variation in prevalence rates may be attributable to the failure to distinguish tardive dyskinesia from dyskinesia-like symptoms caused by withdrawal from antipsychotic drugs. See, e.g., *APA Task Force* 43-44 (roughly 10-20% of mental hospital patients and 40% of elderly, chronically institutionalized or outpatients exhibit more than minimal signs of tardive dyskinesia); Gardos & Cole, *Overview: Public Health Issues in Tardive Dyskinesia*, 137 Am. J. Psychiatry 776, 776-777 (1980); Gardos *et al.*, *Withdrawal Syndromes Associated with Antipsychotic Drugs*, 135 Am. J. Psychiatry 1321 (1978); Kane & Smith, *Tardive Dyskinesia*, 39 Archives Gen.

ble if medication is halted or if other drugs are also used.⁸ But there is disagreement within the psychiatric community on that issue, and on others as well.⁹ As the en banc Fourth Circuit recently summarized: "Without exhaustive analysis of the scientific literature before us documenting these side-effects and their statistical probability, it suffices to observe that while there is universal agreement in the relevant professional discipline that the side-effects always exist as a risk, there is wide disagreement within those disciplines as to the degree of their severity, their susceptibility to treatment, their duration, and, most significantly, their probability over the run of cases." *Charters*, 863 F.2d at 310-311.

Psychiatry 473, 479 (1982) (tardive dyskinesia does not develop in 80% of patients and perhaps 25% of treated patients may have abnormal movements for independent reasons); Jeste & Wyatt, 138 Am. J. Psychiatry at 302-304 (36 studies from 1960-1980 show an overall incidence rate of 17.5% for tardive dyskinesia among chronically ill mental patients treated with antipsychotic drugs; after discounting reversible forms of dyskinesia, the prevalence of persistent dyskinesia attributable to antipsychotic drugs is about 13%).

⁸ See, e.g., *APA Task Force* 44 (25-50% of cases are potentially reversible); Crane, *Persistent Dyskinesia*, 122 Brit. J. Psychiatry 395, 399 (1973) (early diagnosis and withdrawal of medication may contribute to recovery, but symptoms persist in a large number of patients); Jeste & Wyatt, 5 Schizophrenia Bull. at 26, 31 (tardive dyskinesia initially worsens after drug withdrawal, but it tends to disappear over time in a variable proportion of patients); Jeste & Wyatt, 138 Am. J. Psychiatry at 297, 303 (dyskinesia is reversible in more than one-third of all patients, and the rate of reversibility is likely to be higher among young patients than the elderly, but there is no satisfactory treatment for tardive dyskinesia); Jus *et al.*, *Long Term Treatment of Tardive Dyskinesia*, J. Clinical Psychiatry 72 (Feb. 1979); Quitkin *et al.*, 134 Am. J. Psychiatry at 84, 86 (first signs of tardive dyskinesia may be reversible). But see Gardos & Cole, 137 Am. J. Psychiatry at 780 (effectiveness of early intervention remains to be proved).

⁹ For example, there is conflicting evidence on the relationship between cumulative drug dosage or the length of treatment and the prevalence of tardive dyskinesia. *APA Task Force* 51; Kane & Smith, 39 Archives Gen. Psychiatry at 475-476. The factors that contribute to a person's susceptibility are not clearly established, *APA Task Force* 51-52, but some have suggested that elderly and brain-damaged patients are more likely to have persistent dyskinesia, *ibid.*; Baldessarini, 46 J. Clinical Psychiatry at 10, 11; Jeste & Wyatt, 5 Schizophrenia Bull. at 25.

2. In 1976, respondent Walter Harper pleaded guilty to robbery and was sentenced to 20 years' imprisonment.¹⁰ He has been alternatively diagnosed as suffering from schizophrenia, schizoaffective disorder, and manic depression, and he has a history of assaultive behavior, which physicians have attributed to his illness. Respondent was primarily confined in the mental health unit, and on several occasions he was transferred to a state hospital for evaluation and treatment.¹¹ Respondent was paroled in 1980 on the condition that he participate in outpatient psychiatric treatment. While on parole, respondent was twice committed to a hospital for psychiatric treatment. Respondent's parole was revoked in December 1981 after he assaulted two hospital staff members. Pet. App. A2-A3, B4, B5.

Upon returning to prison, respondent was transferred to the Special Offender Center (SOC), a 144-bed state institution that employs psychiatrists, psychologists, and therapists to treat convicted felons with serious mental or behavioral disorders. Respondent voluntarily participated in treatment at the SOC, including the receipt of antipsychotic medication from January to February 1982 and from May to November 1982. At that point, however, respondent refused further medication. Respondent's treating physician then sought to medicate respondent over his objection pursuant to the SOC policy regarding the involuntary administration of antipsychotic drugs. Pet. App. A3, B4-B5.¹²

¹⁰ Judgment and Sentence, *State v. Harper*, No. 3415 (July 30, 1976) (Book 4). "Book" refers to the discovery books that were submitted by the State in response to respondent's discovery requests and that were considered by the state trial court. Pet. App. B1.

¹¹ While confined, respondent committed at least 29 disciplinary infractions for fighting, assault, setting fires (five times), threatening bodily harm, destroying property, possessing narcotics, and theft. Tolstad (Classification Counselor), Overview (Jan. 13, 1982) (Book 4).

¹² The current SOC policy is contained in a memorandum, Department of Corrections, *Institutional Policy and Procedures*, No. SOC 620.200, *Involuntary Medication Policy* (Feb. 18, 1985) [hereinafter *SOC Policy*] (Book 9). The policy was adopted in part in response to *Vitek v. Jones*, 445 U.S. 480

That policy has several components: *First*, a prisoner can be involuntarily medicated only if he suffers from a "mental disorder"¹³ and is "gravely disabled"¹⁴ or if he poses a "likelihood of serious harm" to himself, others, or their property.¹⁵ Pet. App. A9 n.7, B3; *SOC Policy* 1. *Second*, medication must be ordered by, or in the case of emergencies approved by, a psychiatrist.¹⁶ If an inmate refuses medication, it cannot be administered until it is approved by a hearing committee consisting of a psychiatrist, a psychologist, and the SOC associate superintendent. The attending physician must prepare for the committee an evaluation of the inmate, which documents the in-

(1980), which held that due process requires a hearing before a prisoner may be transferred to a mental hospital. Pet. App. B3.

¹³ A "mental disorder" is defined under Washington law as "any organic, mental, or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions." Wash. Rev. Code Ann. § 71.05.020(2) (West Supp. 1989).

¹⁴ "Gravely disabled" means "a condition in which a person, as a result of a mental disorder: (a) [i]s in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety, or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety." Wash. Rev. Code Ann. § 71.05.020(1) (West Supp. 1989).

¹⁵ "Likelihood of serious harm means either: (a) [a] substantial risk that physical harm will be inflicted by an individual upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on one's self, (b) a substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places such another person or persons in reasonable fear of sustaining such harm, or (c) a substantial risk that physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused a substantial loss or damage to the property of others." Wash. Rev. Code Ann. § 71.05.020(3) (West Supp. 1989).

¹⁶ "An emergency will be deemed to exist when, in the judgment of a licensed health professional with prescriptive authority, an inmate is suffering from mental disorder and, as a result of that disorder, presents an imminent likelihood of serious harm to himself or others." *SOC Policy* 2. When medication is prescribed in an emergency, a psychiatrist must be consulted within 24 hours. If he approves its use, medication may be continued for a full 72-hour period. *Ibid.*

mate's mental condition, the risk that he will injure himself or others, the methods used to persuade him to accept medication voluntarily, and his response to those efforts. The committee decides by majority vote whether a prisoner is gravely disabled or dangerous, but the psychiatrist must be in the majority for the medication to be approved. None of the committee members may be currently involved in the prisoner's diagnosis or treatment, but a former treating physician may sit on subsequent review panels. Pet. App. A7, B3; *SOC Policy* 2-3.

Third, the prisoner has certain procedural rights prior to and at the hearing. He must receive 24 hours' notice of the hearing, during which time he may not be medicated. He must also be given notice of the tentative diagnosis, the data reflecting the factual basis for that diagnosis, and the reason medication is deemed necessary. Before the hearing begins, the committee consults with the staff outside the patient's presence to determine whether the SOC policy requirements have been satisfied and what the staff position will be at the hearing. The staff presents its reasons why the patient is considered dangerous and why his condition is believed to be the product of his mental disorder. At the hearing, the prisoner has the right to be present, to present evidence (including witnesses), and to question the institution's witnesses. A prisoner is not given counsel, but an inmate has the right to an adviser not previously involved with the case who understands the psychiatric issues that the case may raise. The inmate is excused during the committee's deliberations, but he is returned for its decision. Minutes of the hearing must be kept and a copy provided to the inmate. An inmate may appeal the committee's decision to the SOC superintendent within 24 hours, and the superintendent must act on the appeal within 24 hours of its receipt. A prisoner may seek judicial review in state court of the decision to medicate him. Pet. App. A6-A7, B6, B8-B9; *SOC Policy* 4-6.

Fourth, a course of medication must be periodically reviewed. At the time of respondent's treatment, the committee would re-examine each inmate's case after seven days of treatment. If the committee reapproved medication, the treating psychiatrist had

to review the prisoner's case and prepare a report for the Department of Corrections medical director every 14 days throughout the prisoner's course of treatment. Pet. App. B4.¹⁷

Those procedures were followed in respondent's case. Two physicians and the SOC associate superintendent sat on the special hearing committee. Respondent was present and was assisted by a nurse practitioner from another institution. The committee found that respondent was a danger to others due to a mental disease or disorder, and it authorized respondent's involuntary medication. Respondent appealed the committee's decision to the SOC superintendent, who upheld the committee's findings. Respondent was treated for approximately one year beginning on November 23, 1982, during which time his case was periodically reviewed as required by the SOC policy. Respondent received a variety of antipsychotic drugs that have various potential short- and long-term side effects, some of which respondent may have exhibited. Pet. App. A3-A4, A7, B5-B6, B8.¹⁸

In November 1983, respondent was transferred from the SOC to a reformatory, where he did not take his medication. His mental condition deteriorated, and he was returned to the SOC in December 1983. After another hearing, the committee decided to resume respondent's medication. Treatment continued until June 1986, when respondent was transferred to a state prison. Throughout that period, respondent's condition was reviewed in accordance with the SOC policy. Each time, his

¹⁷ The review mechanism was later altered slightly. The initial treatment period was lengthened from seven to 14 days, but the special hearing committee still reviewed the prisoner's case at the end of that period. The biweekly reporting requirement was maintained, and if treatment continued for 180 days, a new hearing was held to consider whether further treatment was necessary. Pet. App. B4.

¹⁸ The drugs included Trialafon, Haldol, Prolixin, Taractan, Loxitane, Mellaril, and Navane. Pet. App. A4 n.3, B7. The potential side effects of those drugs include dystonia, akathisia, and tardive dyskinesia. While being treated, respondent exhibited symptoms of dystonia and akathisia and was treated for them. Respondent did not exhibit signs of tardive dyskinesia. *Id.* at A5 n.4, B8.

medication was continued, although the specific drugs or dosages were sometimes changed. Pet. App. A3, B5-B7.¹⁹

3. In February 1985, respondent brought this action in state court under 42 U.S.C. 1983, claiming that the failure to provide him with a judicial hearing before he was involuntarily medicated violated the Due Process, Equal Protection, and Free Speech Clauses of the federal and state constitutions, as well as state tort law. J.A. 7-8. Following a bench trial, the court held that respondent had a liberty interest in not being involuntarily subjected to antipsychotic medication, but that the SOC policy satisfied due process requirements under *Vitek v. Jones*, 445 U.S. 480 (1980). Pet. App. B8-B9.

4. Respondent appealed, and the Washington Supreme Court reversed, holding that respondent was entitled to a judicial hearing before again being involuntarily medicated. Pet. App. A1-A13. Like the trial court, the Washington Supreme Court held that respondent had a liberty interest in not being treated with antipsychotic medication. *Id.* at A4-A6. But the court held that the procedures guaranteed by *Vitek* were insufficient and that a judicial hearing is required before a prisoner can be given antipsychotic medication involuntarily. *Ibid.* The Washington Supreme Court further held that a court can order a prisoner to be treated with antipsychotic drugs against his will only if the State can show by "clear, cogent, and compelling evidence" that there is a compelling interest in using antipsychotic drugs in the prisoner's treatment and that the use of the drugs is necessary and will be effective to further that interest. *Id.* at A10, A11. The court indicated that the State could establish a compelling interest by showing, for example, that the

¹⁹ Respondent is apparently not receiving any medication involuntarily at present, but that fact does not moot his claim for declaratory and injunctive relief. Because respondent is seriously mentally disturbed and has not yet been released from prison, there is a reasonable likelihood that he could again be involuntarily medicated, particularly if the judgment below is reversed. Thus, the dispute between the parties can reasonably be expected to recur. *Vitek*, 445 U.S. at 486-487.

medication is necessary for the "(1) preservation of life; (2) protection of third parties' interests; (3) prevention of suicide; and (4) maintenance of the ethical integrity of the medical profession." *Id.* at A10. If the State proves a compelling need for medication, the court must then decide whether that treatment is necessary and effective, a decision that requires consideration of the inmate's prognosis with and without the medication, and under alternative treatments. *Ibid.* The court must then consider the inmate's own wishes, including his "previous and current statements," his "religious and moral values" regarding medical treatment in general and antipsychotic drug treatment in particular, and the "views of individuals that might influence the patient's decision." *Id.* at A10-A11 (citation omitted). If the prisoner is unable fully to understand the nature of the hearing, "as severely mentally ill patients often are," the court must substitute its judgment for that of the prisoner. *Id.* at A11.

The Washington Supreme Court also dictated the procedures required at the judicial hearing. The court held that as a matter of due process the inmate must be afforded the following rights: (1) reasonable notice of the hearing; (2) the right to be present; (3) the right to be represented by counsel; (4) the right to present evidence; (5) the right to cross-examine witnesses; (6) the right to remain silent; (7) the right to have the proceeding conducted in accordance with the rules of evidence; and (8) the right to examine and copy all documents in the court's file. Pet. App. A11. Finally, the court held that the court assigned to the matter may impose "such time limits and conditions" on the use of antipsychotic medication "as are appropriate under the circumstances of the case." *Ibid.*²⁰

²⁰ In light of its decision on the due process issue, the Washington Supreme Court did not address respondent's equal protection and free speech claims. Pet. App. A4 n.2.

On April 20, 1989, after the Court granted certiorari in this case, the State enacted a law, Substitute Senate Bill No. 5362, ch. 120, Laws 1989, that essentially adopted the procedures required by the decision below for all civilly committed mental patients. The act excludes correctional institutions and facilities from its scope.

INTRODUCTION AND SUMMARY OF ARGUMENT

The Washington Supreme Court held that, at least in the absence of an emergency, only a court can order the involuntary administration of antipsychotic drugs to a mentally ill and dangerous prisoner. Moreover, the court held that such treatment may be ordered only after an adversary judicial hearing at which the State must establish that the inmate would choose that treatment if he were competent, or that the treatment, in the court's opinion, is in the inmate's best interest. That analysis, we submit, is wrong.²¹

²¹ Since this Court's decision in *Youngberg v. Romeo*, 457 U.S. 307 (1982), which adopted a "professional judgment" standard to govern the involuntary use of restraints on a mentally retarded person, the federal courts have generally held that due process does not require a judicial hearing before antipsychotic medication can be ordered, and that the correct judicial inquiry is simply whether the responsible treating physician, in the exercise of professional judgment, has found that the use of such drugs is necessary to treat the patient. *Charters*, 863 F.2d at 307-313; *Dautremont v. Broadlawns Hosp.*, 827 F.2d 291, 297-300 (8th Cir. 1987); *Johnson v. Silvers*, 742 F.2d 823 (4th Cir. 1984); *Project Release v. Prevost*, 722 F.2d 960, 980-981 (2d Cir. 1983); *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983) (en banc); *United States v. Bryant*, 670 F. Supp. 840 (D. Minn. 1987); *Stensvad v. Reivitz*, 601 F. Supp. 128, 130-131 (W.D. Wis. 1985); *R.A.J. v. Miller*, 590 F. Supp. 1319, 1321-1323 (N.D. Tex. 1984); *United States v. Leatherman*, 580 F. Supp. 977, 979-980 (D.D.C. 1983), appeal dismissed, 729 F.2d 863 (D.C. Cir. 1984) (Table). But cf. *Bee v. Greaves*, 744 F.2d 1387, 1392-1396 & n.7 (10th Cir. 1984) (pretrial detainees have a due process right to refuse antipsychotic medication absent an emergency and a less restrictive restraint); *Walters v. Western State Hosp.*, 864 F.2d 695 (10th Cir. 1988).

By contrast, many state courts, principally as a matter of state law, have required a judicial hearing to determine the competence of a prisoner or patient to make treatment decisions before antipsychotic medication can be administered involuntarily in a nonemergency situation. See, e.g., *Keyhea v. Rushen*, 178 Cal. App. 3d 526, 223 Cal. Rptr. 746 (1986); *In re Orr*, 176 Ill. App. 3d 498, 531 N.E.2d 64 (1988); *Opinion of the Justices*, 123 N.H. 554, 465 A.2d 484 (1983); *In re Mental Health of K.K.B.*, 609 P.2d 747 (Okla. 1980); *State ex rel. Jones v. Gerhardstein*, 141 Wis. 2d 710, 416 N.W.2d 883 (Wis. 1987). Of those States, some require the court to enter a substituted judgment on behalf of the incompetent patient. *Riese v. St. Mary's Hosp. & Medical Ctr.*, 196 Cal. App. 3d 1388, 243 Cal. Rptr. 241 (1987); *In re Bryant*, 542 A.2d 1216 (D.C. 1988); *Rogers v. Commissioner*, 390 Mass. 489, 458 N.E.2d 308

The question whether antipsychotic drugs may be prescribed for an unwilling patient has substantive and procedural aspects. *Mills v. Rogers*, 457 U.S. 291, 299 (1982). The substantive aspect involves the determination whether the patient has a liberty interest in refusing such treatment, and whether the interests supporting treatment can outweigh the patient's interest in refusing it. The procedural component of that question involves the way in which the determination is made as to whether a particular individual should be involuntarily medicated.

A. In our view, the involuntary administration of antipsychotic drugs affects a constitutionally protected liberty interest, but antipsychotic medication may nonetheless be involuntarily administered to a prisoner who is gravely disabled by his mental illness. The SOC treatment policy creates a liberty interest in the inmate not to receive antipsychotic drugs against the inmate's will. Even apart from the SOC policy, however, an inmate generally enjoys such a liberty interest, because of the effects of the drugs on mentation and behavior, and because the drugs pose a risk of potentially severe and permanent side effects. Balanced against that interest, however, are the interests of others in personal security as well as the interest in helping the inmate overcome his illness. In light of the substantial agreement in the medical profession that antipsychotic drugs can be

(1983); *In re Schuoler*, 106 Wash. 2d 500, 507, 723 P.2d 1103, 1108 (1986). Others require the court to make a treatment determination based upon a variety of factors. *Large v. Superior Court*, 148 Ariz. 229, 244, 714 P.2d 399, 409 (1986) (treatment must be authorized by proper procedural regulations and prescribed for valid medical reasons); *People v. Medina*, 705 P.2d 961, 963-964 (Colo. 1985) (court must consider the necessity of the treatment, the availability of less obtrusive alternatives, the patient's need for the treatment, and the patient's interest in refusing treatment); *In re Mental Commitment of M.P.*, 510 N.E.2d 645, 647 (Ind. 1987) (professional judgment standard insufficient to encompass all the factors that a court must consider); *Jarvis v. Levine*, 418 N.W.2d 139, 148 (Minn. 1988) (court shall appoint a guardian ad litem to represent the interests of the patient and shall determine the necessity and reasonableness of the prescribed treatment); *Rivers v. Katz*, 67 N.Y.2d 485, 497-498, 495 N.E.2d 337, 343-344, 504 N.Y.S.2d 74, 81 (1986) (treatment must be narrowly tailored to protect patient's liberty interest).

effective in treating at least some forms of serious mental illness, the interests in administering treatment can overcome the inmate's liberty interest in appropriate cases.

B. The question whether medication should be ordered in a particular case is a clinical decision that should be made by a physician, not a judge. For that reason, the Washington Supreme Court erred in holding that due process forbids the administration of antipsychotic medication against an inmate's will unless the course of treatment is approved by a court. In *Parham v. J.R.*, 442 U.S. 584 (1979), and *Youngberg v. Romeo*, 457 U.S. 307 (1982), this Court held that a judicial hearing was not necessary before medical professionals could make treatment decisions about a mentally disabled patient. When fairly debatable treatment decisions are at issue, *Parham* and *Youngberg* dictate that a court should show deference to the judgment of a qualified professional and limit the judicial role to determining whether professional judgment was in fact exercised in the particular case. The Washington Supreme Court envisioned a much greater role for the court in reviewing the treatment recommendations of the treating physicians; it therefore insisted on more than is required by the governing due process principles.

The procedures set forth in the SOC policy are sufficient to satisfy any possible due process objection. Under the SOC policy, treatment decisions are reviewed by a panel of medical professionals, the inmate is given notice and an opportunity to participate in the hearing, he is advised of the diagnosis and the reasons for the proposed treatment, and he is provided with a medical professional to assist him in presenting his views. The additional measures ordered by the Washington Supreme Court, such as the assistance of counsel and the disqualification from reviewing responsibility of any physician who had previously treated the inmate, would not contribute significantly to the accuracy of the treatment determination. Those measures are therefore not essential elements of due process in this setting.

ARGUMENT

DUE PROCESS DOES NOT REQUIRE AN ADVERSARIAL JUDICIAL HEARING BEFORE A MEDICAL PROFESSIONAL CAN ADMINISTER ANTI-PSYCHOTIC MEDICATION TO A MENTALLY ILL AND DANGEROUS PRISONER AGAINST HIS WILL

A. Antipsychotic Medication May Be Administered To A Mentally Ill Prisoner Against His Will In Order To Prevent Him From Endangering Himself Or Others

1. The question whether respondent has a liberty interest that is implicated by the use of antipsychotic drugs should be answered in the first instance by reference to state law, such as the SOC policy. *Mills*, 457 U.S. at 305; *Vitek*, 445 U.S. at 488-491. That policy imposes substantive and procedural limits on involuntary drug treatments. In that respect, the SOC policy is similar to the statute considered in *Vitek*, which placed restrictions on transferring an inmate to a mental hospital, and *Vitek* held that the statute created a liberty interest against arbitrary transfers. *Id.* at 488-491. The SOC policy therefore creates a similar liberty interest against arbitrary medication.

Even if state law did not create a liberty interest, we believe that a prison inmate ordinarily retains a liberty interest in not receiving antipsychotic medication against his will. That is true even as to an inmate who is properly confined in a mental ward or hospital, because the decision to commit a prisoner to a mental ward or hospital does not necessarily encompass the judgment that the prisoner should be subjected to treatment with antipsychotic drugs. First, antipsychotic drugs are prescribed only for severely mentally ill patients. A State, however, may transfer prisoners with lesser degrees of mental illness to a psychiatric facility. Thus, antipsychotic medication is not likely to be an appropriate treatment for every inmate in a prison mental hospital. Second, antipsychotic drugs differ in kind, not just in degree, from the types of restraints and stigmas normally associated with the finding that a person has committed a crime and that he is mentally ill, because those drugs have the poten-

tial for severe and lasting side effects. Prescribing such drugs for an inmate thus implicates an interest in bodily integrity of a kind historically recognized by the Anglo-American common law.²² Given the nature of the intrusion resulting from antipsychotic drugs, that interest is not extinguished by the fact of lawful confinement in a facility that serves all mentally ill prisoners. Thus, an inmate ordinarily has a residual liberty interest in not being treated with antipsychotic medication against his will, even if he is properly confined in a prison mental hospital. See *DeShaney v. Winnebago County Dep't of Social Services*, 109 S. Ct. 998, 1006 n.8 (1989).

2. Although a prisoner in a mental ward has a constitutionally protected interest in not being subjected to involuntary treatment with antipsychotic drugs, that interest can be overcome by competing interests invoked by the State. In *Youngberg v. Romeo*, *supra*, this Court held that a person involuntarily committed to an institution for the mentally retarded has a liberty interest in safety and freedom from bodily restraints. 457 U.S. at 315-316. At the same time, the Court recognized that, since those interests could conflict with each other or with similar interests of other persons at the institution, the inmate's liberty interest is not absolute and must be weighed against competing concerns. *Id.* at 320-321; see *Jacobson v. Massachusetts*, 197 U.S. 11, 29-38 (1905) (upholding compulsory smallpox vaccination despite its potential health risks). The same is true here. The interest of a gravely disabled prisoner in electing not to accept powerful medication and in avoiding the potentially harmful side effects of that medication must be balanced against the need to prevent that prisoner from harming

²² At common law a competent adult has traditionally had the right to refuse medical treatment, and involuntary medical treatment of a competent individual has been treated as a battery absent his consent or an emergency. See, e.g., *Mills*, 457 U.S. at 294 n.4; *Medina*, 705 P.2d at 963; *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914) (Cardozo, J.); F. Harper, F. James, Jr., & O. Gray, *The Law of Torts* § 17.1 (2d ed. 1986); W. Keeton, *Prosser and Keeton on The Law of Torts* § 18, at 116-119 (5th ed. Supp. 1984); see generally *Davis v. Hubbard*, 506 F. Supp. 915, 930-932 (N.D. Ohio 1980). The common law protection did not extend, however, to the mentally ill. See, e.g., *Denny v. Tyler*, 85 Mass. (3 Allen) 225 (1861); Note, 82 Colum. L. Rev. 1720, 1722 (1982).

himself, other prisoners, or the institution's personnel or facilities. The prisoner's liberty interest must also be weighed against the prospect that antipsychotic medication will alleviate the prisoner's suffering and return to him the ability to function in a more normal fashion both within and outside the hospital environment.

The paramount concerns in running a prison or a prison mental health facility are maintaining institutional security, preserving internal order, and establishing a therapeutic environment. Prisons are places of involuntary confinement for individuals with "a demonstrated proclivity for antisocial criminal, and often violent, conduct," *Hudson v. Palmer*, 468 U.S. 517, 526 (1984), and "maintaining institutional security and preserving internal order and discipline are essential goals," *Bell v. Wolfish*, 441 U.S. 520, 546 (1979). A prisoner whose untreated mental illness can lead to violence poses a risk to others in several ways. The most obvious is that the prisoner may assault other inmates, staff, or visitors either spontaneously or due to some real or perceived provocation. Moreover, since a mentally ill prisoner is marked by inappropriate behavior, he may often be an inviting target for theft, assault, and other crimes by inmates who believe that he will prove to be easy prey and that hospital personnel will ignore his complaints because of his illness. If his illness renders him susceptible to persuasion, an inmate can also be used by manipulative prisoners as an unwitting accomplice or as a surrogate for their own crimes. Finally, it goes without saying that the interest in preventing violence and maintaining order is significantly amplified when an entire ward consists of mentally ill prisoners, as at the SOC. For these reasons, the courts have uniformly recognized that antipsychotic drugs can be prescribed on an emergency basis for a patient who poses an immediate threat to himself or others.²³

²³ See, e.g., *Bee*, 744 F.2d at 1395-1396; *Rennie*, 720 F.2d at 269; *Davis*, 506 F. Supp. at 935; *Large*, 148 Ariz. at 239, 714 P.2d at 409; *Riese*, 243 Cal. Rptr. at 246; *Medina*, 705 P.2d at 974; *In re Orr*, 531 N.E.2d at 72; *Gundy v. Pauley*, 619 S.W.2d 730, 731 (Ky. Ct. App. 1981); *Rogers*, 390 Mass. at 489, 458 N.E.2d at 321; *Opinion of the Justices*, 123 N.H. at 736, 465 A.2d at

Actual emergencies do not mark the limits of the interest in security. Hospital personnel must be able to protect against the risk, and not just the fact, of violence. It is well known that "[p]rison life, and relations between the inmates and prison officials or staff, contain the ever-present potential for violent confrontation and conflagration." *Jones v. North Carolina Prisoners' Labor Union*, 433 U.S. 119, 132 (1977). While medical personnel and correctional officials at a prison mental hospital may not act purely on speculation that a mentally ill prisoner may create a risk of danger, an inmate's personal or case history may include prior acts or threats of violence, or other symptoms indicating a serious potential for violence, and those officials must be concerned about that potential. A psychiatrist may be able to predict that an inmate is likely to act violently, see *Barefoot v. Estelle*, 463 U.S. 880, 896-902 (1983), but may find it quite difficult to foresee when that will happen. See *Rogers v. Okin*, 634 F.2d 650, 655-657 (1st Cir. 1980), vacated and remanded, *Mills v. Rogers*, *supra*; Schultz, *The Boston State Hospital Case: A Conflict of Civil Liberties and True Liberalism*, 139 Am. J. Psychiatry 183 (1982). Hospital personnel therefore must be able to take reasonable steps to forestall a threat of violence before it culminates in an assault. Of course, it may be possible to restrain a prisoner physically or to place a prisoner in isolation, but such measures will not always be feasible or preferable, particularly for a large number of inmates. And turning a mental ward into an armed camp hardly creates a supportive therapeutic environment.

While restraints may be adequate as means of preventing a prisoner from injuring himself or others, antipsychotic medication in many cases may be the only means of serving both short- and long-term therapeutic goals. Medication may sometimes be the only effective treatment that can enable an inmate to escape

489; *Katz*, 67 N.Y.2d at 495, 495 N.E.2d at 343, 504 N.Y.S.2d at 80; *In re Mental Health of K.K.B.*, 609 P.2d at 750; *In re Schuoler*, 106 Wash. 2d at 508, 723 P.2d at 1108; *Gerhardstein*, 141 Wis. 2d at 736, 416 N.W.2d at 894.

indefinite, if not permanent, hospitalization in a closely supervised environment. In some cases, the failure to medicate a mentally ill patient can result in the irreversible progression of his disease, which by any objective standard can be a far more harmful consequence than the ordinary side effects of antipsychotic medication. For that reason, it is important to recognize that any treatment decision—including the decision not to prescribe medication—is a decision that may do great harm to the patient, perhaps irreversibly. The interests that compete with the inmate's liberty interest are therefore of the greatest potential importance to the welfare of others and, indeed, of the inmate himself.

B. Due Process Does Not Require A Judicial Hearing Before A Medical Professional May Order Antipsychotic Medication To Be Administered To A Mentally Ill And Dangerous Prisoner

1. The next question is what procedures are necessary to decide the issues that arise in each case: e.g., whether antipsychotic medication is an appropriate treatment for a particular inmate, whether a specific medication will alleviate the symptoms of an inmate's illness, whether the potential side effects militate against that treatment, and whether a specific course of medication should be modified or discontinued. This Court's decisions in *Parham* and *Youngberg* are instructive on that point. *Parham* and *Youngberg* involved closely related issues of psychiatric commitment and treatment, and this Court did not require a judicial hearing before a medical professional could make clinical judgments about a person's mental condition and his likely response to treatment.

Parham involved the question whether due process requires an adversary judicial hearing before a hospital may admit a mentally ill child at the request of his parents. This Court rejected any such requirement, holding that a parent's judgment that his child needs such care, coupled with an independent psychiatric finding to that effect, sufficiently ensures that a child will not be arbitrarily hospitalized. 442 U.S. at 606-613. In so ruling, the

Court rejected "the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing." *Id.* at 609. The reason is that "[c]ommon human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real." *Ibid.* See also *Secretary of Public Welfare v. Institutionalized Juveniles*, 442 U.S. 640 (1979).

In *Youngberg*, the Court held that the standard for reviewing the treatment decisions by medical personnel (there, a decision to restrain a mentally retarded patient) must take into account the fact that strict scrutiny of such treatment decisions would unduly interfere with the exercise of professional judgment as to the needs of residents. The Court explained that "there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions." 457 U.S. at 322-323. Rather, "courts must show deference to the judgment exercised by a qualified professional," *id.* at 322, whose decision "is presumptively valid," *id.* at 323. For that reason, the Court held that "the Constitution only requires that the courts make certain that professional judgment in fact was exercised," and that "[i]t is not appropriate for the courts to specify which of several professionally acceptable choices should have been made." *Id.* at 321 (citation omitted). Accordingly, "liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment." *Id.* at 323.

The analysis in *Parham* and *Youngberg* is applicable here. The questions to be resolved in each case involve clinical decisions about the proper treatment for a specific prisoner. Because antipsychotic drugs are generally recognized as an acceptable treatment for mentally ill patients in at least some cir-

cumstances, the only question in a particular case is whether that generally appropriate treatment is indicated for a specific patient. And that is a quintessentially medical judgment. A court therefore should be reluctant to substitute its judgment for that of a physician, and due process does not require that a court be given that responsibility.

That conclusion is sensible. An adversary judicial process is a valuable decisionmaking procedure when the dispute requires the decisionmaker to establish a new rule of law, or when legal questions predominate. Judges and lawyers are trained in the law and have expertise that helps to minimize the risk of error in such a decision. But when the question is whether a particular medication will successfully treat a mentally disordered inmate, psychiatrists are more likely to be able to minimize the risk of error than judges.

Requiring a court to substitute its judgment for that of a mentally ill and dangerous prisoner or to rest its judgment on the prisoner's wishes is likely to be an exercise in futility. A "substituted judgment" approach assumes that it is possible to predict what a mentally ill person would do if he were competent. If a prisoner is incompetent, which the court below recognized is often the case with the severely mentally ill, Pet. App. A11, inquiring what his judgment would be if he were competent may amount to little more than camouflaging the court's own judgment by pretending that it is in effect the prisoner's. And permitting even a competent inmate to refuse medication that is necessary to prevent him from injuring others gives the inmate a veto over the equally important liberty interests of other inmates or persons at the facility or in the community. That price is too high.

The proper approach is to rely on the professional judgment of the treating physician. That judgment should consider the accepted medical practices in diagnosis, prognosis, and treatment, and the use of such techniques and tools as are accepted and appropriate in the medical profession. Factors such as the inmate's medical history, his current mental status, the likelihood that he will become violent (and in what manner) without medication,

his past responses to particular drugs, the possible side effects of a proposed medication, the prisoner's prognosis with and without medication, the ability of less potent drugs to achieve the same effect, and the duration of the past and proposed courses of medication, are among the relevant factors to be considered by a treating physician. *Charters*, 863 F.2d at 312. The physician's judgment is subject to judicial review, but the ultimate inquiry for the court should be whether the physician exercised his professional judgment, not whether the court believes the physician reached the wrong conclusion.

2. The Washington Supreme Court not only declined to adopt the "physician's professional judgment" as the appropriate standard, but also held that the procedures employed under the SOC treatment policy are constitutionally insufficient to support the determination to administer antipsychotic drugs over an inmate's objection. We submit that the elaborate procedures imposed by the court below are not essential to prevent arbitrary treatment decisions, and thus are not required by the Due Process Clause.

Under the SOC administrative review procedure, two mental health professionals sit on the three-person review committee, the prisoner's treating physician is excluded, and the committee psychiatrist must vote with the majority before drugs can be prescribed. In addition, the inmate has various rights in connection with the hearing, and he can challenge the committee's decision both within the SOC and in state court. The committee must reconsider its initial decision after 14 days, and a physician must re-examine a course of medication on a bi-weekly basis thereafter. If treatment last for 180 days, the committee reviews the need for further medication. Thus, the SOC policy provides for both an independent initial decision by qualified professionals and a follow-up review process.

That mechanism satisfies any possible constitutional objection. In both *Parham* and *Vitek*, this Court held in analogous settings that due process is satisfied if a decision to commit someone to a mental institution is reviewed by medical personnel at that facility, since that decision is "essentially medical in

character," and " 'neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments.' " *Parham*, 442 U.S. at 607, 609 (citation omitted); see *Vitek*, 445 U.S. at 496; *id.* at 500 (Powell, J., concurring in part). The same analysis applies to the psychiatric judgment at issue in this case, and the procedures established by the SOC policy, which were modeled on the procedures approved in *Vitek*, are therefore constitutionally sufficient. See *Project Release v. Prevost*, 722 F.2d 960, 980-981 (2d Cir. 1983); *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983) (en banc) (upholding similar procedures).

Besides requiring an adversary judicial hearing before permitting the administration of antipsychotic drugs over the inmate's objection, the Washington Supreme Court found several other flaws in the SOC policy. We do not believe that any of those perceived flaws supports a valid due process objection.

The state court found that the SOC policy could give rise to a conflict of interest due to the possibility that an inmate's former treating physician could sit on a review panel. Pet. App. A7. That possibility does not render the SOC policy facially invalid, and that criticism is not substantial in any event. A physician does not act as a legal adversary under the SOC policy, and there is no reason to assume that a psychiatrist will indefinitely and blindly adhere to his original clinical judgment if new facts come to light, or that a physician is incapable of impartially deciding whether to alter a course of medication that he once recommended. In fact, physicians routinely re-evaluate a patient's progress under an initial course of medication, and it is common for physicians to modify the prescribed medication after such a reassessment. Furthermore, given the number of psychiatrists and patients at a particular facility, it may be impossible always to avoid using a former treating physician on a review panel. The cost of hiring additional physicians for review panels would reduce the funds otherwise available for treatment, and therefore is a factor counseling against the requirement that a committee member have no prior involvement in a prisoner's case in order to be eligible to review his treatment. Cf. *Parham*, 442 U.S. at 606.

Similarly, due process does not require that the inmate be represented by counsel, as the Washington Supreme Court held. Because the answer to clinical questions "turns on the meaning of facts which must be interpreted by expert psychiatrists and psychologists," *Vitek*, 445 U.S. at 500 (Powell, J., concurring in part) (citation omitted), "it is less than crystal clear why lawyers must be available to identify possible errors in medical judgment," *Walters v. National Ass'n of Radiation Survivors*, 473 U.S. 305, 330 (1985). A lawyer is a valuable assistant if a proceeding is governed by technical rules of procedure and evidence, or if a prisoner faces a professional prosecutor. *Id.* at 333; *Powell v. Alabama*, 287 U.S. 45, 69 (1932). But at a hearing conducted by medical personnel and directed at reaching conclusions about the medical benefits and risks of a particular treatment, an inmate has far less need for a legal assistant than for a medical expert. Cf. *Walters*, 473 U.S. at 334. The SOC policy supplies an inmate with a medical assistant and is therefore sufficient under *Vitek*, 445 U.S. at 497; *id.* at 500 (Powell, J., concurring in part).²⁴

Finally, the court below erred in ruling that a prisoner may invoke his Fifth Amendment privilege against compulsory self-incrimination at the treatment hearing in order to avoid involuntary medication. In *Allen v. Illinois*, 478 U.S. 364 (1986), the Court held that a person may not invoke his privilege at a proceeding on the question whether he is subject to commitment as a "sexually dangerous person," since that proceeding was not "criminal" within the meaning of the privilege. The dispositive factors in *Allen* are also present here.

First, the SOC policy treats medication hearings as civil in nature. See *Allen*, 478 U.S. at 368. The policy states that a prisoner may be involuntarily medicated only if he suffers from

²⁴ Contrary to the ruling of the Washington Supreme Court, due process does not require that the rules of evidence be applied at a treatment hearing. Those rules need not be used at a hearing to determine whether a prisoner is mentally ill and should be transferred to a mental hospital, see *Vitek*, 445 U.S. at 494-495, and there is no greater reason to apply those rules when the issue to be decided concerns the appropriate clinical treatment.

a "mental disorder" and is "gravely disabled" or presents a "likelihood of serious harm" to himself or others, and those terms are taken verbatim from the state laws governing involuntary civil commitment.

Second, there is no suggestion in the SOC policy that treatment hearings are in fact criminal despite their label. *Allen*, 478 U.S. at 369. The SOC is a special facility that is designed to evaluate and treat inmates with serious behavioral or mental disorders, antipsychotic medication may be given only to certain mentally ill inmates, and treatment must be discontinued once a prisoner is no longer mentally disordered, gravely disabled, or likely to injure himself or others. See *Allen*, 478 U.S. at 369-370. Thus, although the SOC policy applies only to prisoners, it "does not appear to promote either of 'the traditional aims of punishment — retribution and deterrence.'" *Id.* at 370 (citation omitted). The privilege against compulsory self-incrimination therefore may not be invoked to avoid the possibility of medication with antipsychotic drugs.

CONCLUSION

The judgment of the Supreme Court of Washington should be reversed.

Respectfully submitted.

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MAY 1989

AMICUS CURIAE

BRIEF

No. 88-599

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**BRIEF FOR
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WASHINGTON STATE PSYCHIATRIC ASSOCIATION
AS AMICI CURIAE**

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INTEREST OF AMICI CURIAE

The American Psychiatric Association ("APA"), with approximately 35,000 members, is the nation's leading organization of physicians specializing in psychiatry. The APA has participated as *amicus curiae* in numerous cases involving mental health issues, including *Allen v. Illinois*, 478 U.S. 364 (1986); *Ake v. Oklahoma*, 470 U.S. 68 (1985); *Barefoot v. Estelle*, 463 U.S. 880 (1983); *Youngberg v. Romeo*, 457 U.S. 307 (1982); *Estelle v. Smith*, 451 U.S. 454 (1981); *Parham v. J.R.*, 442 U.S. 584 (1979); *Addington v. Texas*, 441 U.S. 418 (1979); and *O'Connor v. Donaldson*, 442 U.S. 563, on remand, 519 F.2d 59 (5th Cir. 1975).

This case deals with the circumstances in which anti-psychotic medication, a basic psychiatric treatment, may be administered to objecting prisoners who have been transferred to a prison-run mental facility for treatment in accordance with procedures established in *Vitek v.*

Jones, 445 U.S. 480 (1980). Because the APA views this issue as having a very significant impact on the appropriate care and treatment of all persons confined for treatment to mental institutions, it has participated in almost every federal appellate case presenting similar questions. See, e.g., *Mills v. Rogers*, 457 U.S. 291 (1982); *United States v. Charters*, 863 F.2d 302 (4th Cir. 1988) (*en banc*), stay granted, 57 U.S.L.W. 3545 (Feb. 14, 1989); *United States v. Leatherman*, 729 F.2d 863 (D.C. Cir. 1984); *Project Release v. Prevost*, 722 F.2d 960 (2d Cir. 1983); *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983) (*en banc*). The APA believes that the experience of its members who work with involuntarily committed patients provides an important perspective for consideration by this Court. In addition, through its studies and research, the APA has developed significant clinical and scientific information that is relevant to this case.

The Washington State Psychiatric Association is the Washington District Branch of the APA and includes about 520 members. It is the largest organization of psychiatrists in the state and is concerned with patient care, physician and community education, and the further development of medical and psychiatric knowledge and practice. The decision under review affects its membership by placing significant constraints on the provision of psychiatric care in Washington.

STATEMENT OF THE CASE

Walter Harper is an incarcerated felon who suffers from schizophrenia. *Harper v. Washington*, Pet. App. B-1, B-5 (Trial Court Findings of Fact). His psychosis has contributed to a history of assaultive behavior. *Ibid.* For more than the past decade, Harper has undergone periodic antipsychotic drug treatment for his illness.¹ His assault-

¹ The terms "antipsychotic," "neuroleptic," and "psychotropic" are commonly used synonymously to refer to medication used to treat thought disorders such as schizophrenia. See R. Baldessarini, *Chemotherapy in Psychiatry*, ch. 2 (rev. ed. 1985). The antipsychotics should not be confused with other major categories of medi-

tive tendencies recede so long as he takes these drugs; when he is unmedicated, the tendencies re-emerge. *Ibid.* Consequently, Harper's medicated periods have coincided with periods of relatively less severe confinement; unmedicated intervals have found him under stricter restraint.

In 1976, Harper was convicted of robbery and incarcerated at Washington State Penitentiary. *Id.* at B-4. While there, he voluntarily accepted antipsychotic medication for his illness. In 1980, Harper was paroled on the condition that he continue to participate in psychiatric treatment. He subsequently entered a hospital psychiatric ward and, afterwards, was civilly committed to a state psychiatric hospital. In December of 1981, his parole was revoked after he assaulted two nurses while a patient at another hospital. *Ibid.*

Upon reincarceration, Harper entered the Washington Special Offender Center ("SOC"), a one hundred and forty-four bed correctional institution administered by the state's Department of Corrections. SOC provides diagnosis and treatment for convicted felons who suffer from serious behavioral or mental disorders. *Id.* at B-2. In this way, the SOC endeavors to bring these prisoners up to a level of functioning that permits their transfer to other state facilities for the duration of their sentences. *Ibid.* In January of 1982, Harper voluntarily commenced an SOC psychiatric treatment program that included antipsychotic medication.

In November of that year, Harper began to refuse the medication prescribed by his treating psychiatrist. Accordingly, the SOC invoked its procedures for involuntary treatment, which were adopted in light of *Vitek v. Jones*, 445 U.S. 450 (1980). *Id.* at B-3. These procedures provide that a prisoner may be involuntarily medicated only after a hearing at which a committee composed of a

cation used in treating mental illness, namely the antidepressants and lithium. These latter drugs address mood, rather than thought, disorders. *Id.* at ch. 3-4.

psychiatrist, a psychologist, and the Associate Superintendent of the SOC agree by majority vote that the prisoner suffers from a mental disorder as a result of which he either is gravely disabled or presents a likelihood of harm to himself or others. *Ibid.*² If the Committee agrees that the patient is in need of medication but refuses treatment, the psychiatrist must concur in the Committee's decision. *Ibid.*

The SOC policy guaranteed to Harper certain procedural rights, including twenty-four hours notice, during which he could not be medicated; notice of the tentative diagnosis, the factual basis for it, and the reasons why medical treatment was necessary. *Ibid.* At the hearing, Harper had the right to be present, to offer evidence, and to cross-examine the staff witnesses. He also had access to the assistance of a lay advisor who had not been involved with the case and who had an understanding of the underlying psychiatric issues. *Ibid.* Pursuant to these procedures, an SOC hearing committee determined that Harper suffered from a mental disease or disorder that caused him to present a danger to others. Accordingly, the Committee directed that he be involuntarily medicated. *Id.* at B-5. This decision was upheld on appeal to the institution superintendent. *Ibid.*

For the next twelve months, Harper involuntarily received antipsychotic medication. His condition appears to

² The SOC medication policy, in turn, borrows from Washington's involuntary commitment statute to define these criteria. *See Harper v. Washington*, Pet. App. A-1, A-9 (Washington State Supreme Court).

(1) "Gravely disabled" means a condition in which a person, as a result of a mental disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his essential human needs of health or safety, or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.

Wash. Rev. Code Ann. § 71.05.020(1) (West Supp. 1988) (As amended April 20, 1989).

have improved to such a degree that he was transferred out of SOC and into the Washington State Reformatory in November of 1983. After his transfer, however, he discontinued medication, *id.* at B-6, and "[c]onsequently, his condition deteriorated, he decompensated, and, on December 22, 1983, he was returned to SOC." *Ibid.*

Again, Harper refused medication; notwithstanding his objections, again, an SOC medication committee determined that Harper suffered a mental disorder as a result of which he presented a danger to others. His treating psychiatrist recommended, and the Committee concurred, that he be treated with antipsychotics. *Ibid.* Pursuant to that determination and periodic reviews thereof, Harper received involuntary antipsychotic treatment until June of 1986, when his improved condition permitted his transfer from SOC to Washington State Penitentiary at Walla Walla. Harper remains, unmedicated, at that institution today. *Ibid.*

During the time he was objecting to antipsychotic medication, Harper complained of and may have exhibited symptoms of acute dystonia, or involuntary spasms, and akathisia, or restlessness. *Id.* at B-8; *see also, Harper v. Washington*, Pet. App. A-1, A-5 n.4 (Washington State Supreme Court). These are "[l]ess serious, reversible, side effects" of antipsychotic medication, for which Harper received treatment. *Ibid.* However, he has never exhibited symptoms of tardive dyskinesia, a more serious potential side effect. *Ibid.*³ Despite his objection to the medication, moreover, Harper has never alleged that his treatment, including the involuntary administration of antipsychotic medication, was inappropriate or substandard. In fact, the trial court expressly found that "[a]t all times relevant to this action, the medical treatment provided to [Harper] by defendants, including the ad-

³ Harper's treating physician believed that while Harper may have suffered some side effects from the medication, the psychiatrist "was sometimes skeptical of [Harper's] complaints . . . and felt that they might be feigned." Findings of Fact, *supra*, Pet. App. at B-8.

ministration of antipsychotic medications, was consistent with the degree of care, skill, and learning expected of a reasonably prudent psychiatrist" Findings of Fact, *supra*, Pet. App. at B-8.

In the instant action, filed in state court under 42 U.S.C. § 1983, Harper claims that the due process clause of the Fourteenth Amendment secured to him a right to refuse treatment with antipsychotic medication that could be overcome only after a full judicial hearing, rather than the independent administrative review provided under SOC procedures. *Id.* at B-2. The Superior Court of the State of Washington dismissed the complaint. While the court agreed that Harper enjoyed a liberty interest in avoiding involuntary medication with antipsychotics, it held that the SOC procedures provided adequate process to protect that right. *Id.* at B-9.

The Supreme Court of Washington reversed. Recognizing a "fundamental liberty interest in refusing antipsychotic drug treatment," *Harper, supra*, Pet. App. at A-6, the court determined that due process requires a full judicial hearing before that interest can be extinguished and a prisoner involuntarily medicated, *id.* at A-8. In such a proceeding, the presiding judge must evaluate the prisoner's desires regarding such treatment. Upon finding the patient "unable to understand fully the nature of the . . . hearing," the court must make a "substituted judgment" for the patient that attempts to approximate what he or she would decide if competent. *Id.* at A-10-11. Should the substituted judgment coincide with the prisoner's original refusal of medication, no antipsychotics may be administered unless the state proves, by "clear, cogent, and convincing evidence," *id.* at A-11, "(1) a compelling state interest to administer antipsychotic drugs, and (2) the administration of the drugs is both necessary and effective for furthering that interest." *Id.* at A-10 (citation and footnote omitted).⁴ The prisoner

⁴ Without indicating in any fashion how a court would weigh these competing interests, the court stated that potentially com-

must be accorded reasonable notice and time to prepare for this hearing, must be present throughout the proceedings, and must be represented by counsel. *Id.* at A-11.

SUMMARY OF ARGUMENT

This case raises the question of whether a mentally ill prisoner who poses a "likelihood of serious harm to others," Findings of Fact, *supra*, Pet. App. at B-8, holds a virtually unfettered constitutional right to refuse medically appropriate treatment with antipsychotic medication. The decision below is based on a fundamentally incorrect understanding of the scientific facts about antipsychotics as well as the governing case law. Not surprisingly, it is also completely at odds with virtually every other federal law decision in the area.

If allowed to stand, the decision below will affect not only those prisoners in Harper's circumstances, but also the thousands of mentally ill persons involuntarily confined under state civil commitment statutes. At best, by interposing daunting, costly, and time-consuming procedural obstacles to the administration of necessary medical care, the decision threatens to delay and disrupt treatment of the refusing patient and others, while diverting scarce professional resources to costly and unproductive judicial proceedings. At worst, by enshrining the preferences of dangerous persons gravely in need of psychiatric treatment, the result threatens to consign those refusing antipsychotic medications to indefinite hospitalization, close confinement, and increased use of physical restraints.

As with any due process inquiry, the Washington court's analysis proceeds in the first instance from an assessment of the liberty interest at stake. In that regard, the court rested its constitutional analysis on its

pellling state interests included "(1) preservation of life; (2) protection of third parties' interests; (3) prevention of suicide; and (4) maintenance of the ethical integrity of the medical profession." *Harper, supra*, Pet. App. at A-10 (citation omitted).

views about antipsychotic medication. Describing such treatment as "uniquely intrusive," the court could discern no distinction between antipsychotic medication and electroconvulsive therapy ("ECT") and psychosurgery. *Harper, supra*, Pet. App. at A-10 n.9; *id.* at A-6. Significantly, in attempting to support these comparisons, the court relied neither on the findings of the trial court, which confirm the safety and efficacy of antipsychotic medications for Harper, nor on the extensive body of clinical literature regarding these medications. Instead, the court drew its opinions from a single medical text and a handful of highly tendentious and outdated judicial decisions. As a consequence, the court's grave concerns about antipsychotics reflect a fundamental misunderstanding of how they work—including their benefits, their potential side effects, and their central role in the treatment of serious mental illness. On the strength of these misinformed views, moreover, the Washington Supreme Court rejected this Court's approach in *Youngberg v. Romeo*, 457 U.S. 307 (1982), which found that a patient has a due process interest in not receiving arbitrary or unwarranted treatment, rather than a right to veto the reasonable treatment choices of medical professionals. Once antipsychotic medications are properly understood, however, the distinction between this case and *Youngberg* cannot withstand scrutiny.

The Washington court's preference for judicial rather than administrative procedures is also misguided. Judicial hearings are unlikely to advance the goal of safeguarding a patient's legitimate due process interest. That interest can best be protected through less formalized, independent, medical review procedures, such as those at issue here, which are designed to ensure professional scrutiny of a treatment decision. The experience of jurisdictions where medication refusals trigger judicial review demonstrates that such procedures are costly and inefficient, while offering no greater protection for the patient from the inappropriate use of medication.

ARGUMENT

The legal standards governing due process analysis in this setting are not subject to dispute. As this Court put it recently, "whether [an involuntarily confined patient's] constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests." *Youngberg, supra*, 457 U.S. at 321. By exaggerating the adverse effects of antipsychotic medications while denigrating their widely-recognized role in the treatment of severe mental illness, the *Harper* Court vastly inflated the intrusion occasioned by their use; and by minimizing the state's legitimate interest in providing safe and effective treatment to mentally ill persons properly confined to mental institutions, the court understates the relevant governmental interests. These basic misunderstandings, in turn, led to the court's misguided and counterproductive preference for judicial hearings.

A. Treatment Involving Psychotropic Medication Does Not Warrant a Unique Constitutional Rule.

The *Harper* Court began and ended its due process analysis by resolving that psychotropic drug therapy is the constitutional equivalent of psychosurgery and ECT. *Harper, supra*, Pet. App. at A-6. This analogy is remarkably inapt and fundamentally misleading. We would agree that non-consensual psychosurgery constitutes precisely the sort of governmental intrusion that would warrant the most demanding due process safeguards—both substantive and procedural—before it could be undertaken by government, assuming it could ever be so undertaken. See 4 *Task Panel Reports Submitted to the President's Commission on Mental Health*, app. at 1435 (1978). Significantly, however, the very factors that call for such careful scrutiny in the context of psychosurgery are wholly absent in the area of antipsychotic medication.

Psychosurgery is an experimental, irreversible, surgical procedure that has engendered considerable con-

troversty concerning its efficacy and whether its potential benefits outweigh its potential risks. See Shevitz, *Psychosurgery: Some Current Observations*, 133 Am. J. Psychiatry 266 (1976). For sound clinical reasons—wholly apart from any constitutional issues that may arise in the context of involuntarily committed patients or mentally ill inmates—it is rarely employed. See Donnelly, *The Incidence of Psychosurgery in the United States, 1971-1973*, 135 Am. J. Psychiatry 1476 (1978). ECT is likewise rarely used as a treatment of first resort, though it has been shown to have demonstrated value in the treatment of some forms of major depressive illness that cannot successfully be treated with medication, or for certain patients, particularly the elderly, for whom the use of medication could be dangerous.⁵

By contrast, the antipsychotic medications that the Harper Court lumped together with psychosurgery and ECT for unique constitutional treatment are the treatment of choice for large numbers of persons suffering from the most severe forms of mental illness. The most recent comprehensive review of the treatment of schizophrenia published by the National Institute of Mental Health indicated: "Antipsychotic (neuroleptic) drugs remain the primary modality in the treatment of an acute episode or an acute exacerbation of a schizophrenic illness." Kane, *Treatment of Schizophrenia*, 13 Schizophrenia Bull. 133, 134 (1987). "The available data do not support the feasibility of substituting any psycho-

⁵ ECT is sometimes "the treatment of choice in the severely debilitated or suicidal depressed person." Rich, "Electroconvulsive Therapy," in 3 *Psychiatry*, ch. 68, p. 8 (R. Michels, et al. rev. ed. 1988). In particular, there are times when an incapacitating depression simply will not respond to other treatments or when the patient is taking other medications that will cause an adverse reaction if an antidepressant is also given. In these circumstances, ECT has been widely shown to be safe and efficacious. *Ibid.* The proper due process analysis with respect to its use is not presented by this case and therefore should not be resolved here.

therapeutic strategy for drug treatment on an indefinite basis." *Id.* at 142.⁶

Psychotropic medication is widely accepted within the psychiatric community as an extraordinarily effective treatment for both acute and chronic psychoses, particularly schizophrenia. The NIMH review concluded that "[a]ntipsychotic (neuroleptic) drugs generally have a dramatic effect on the symptoms of schizophrenia (e.g., delusions, hallucinations, and thought disorder) within 4-6 weeks, although improvement may continue well after that interval." Kane, *supra*, 13 Schizophrenia Bull. at 142. Another review of the data concludes that ninety-five percent of acute schizophrenic patients treated with antipsychotics show improvement within six to eight weeks. Kessler & Waletzky, *Clinical Use of the Antipsychotics*, 138 Am. J. Psychiatry 202, 203 (1981).

The value of antipsychotic medication for the long-term treatment of chronic psychosis is equally well-established. "Maintenance antipsychotic drug treatment has proved to be of enormous value in reducing the risk of psychotic relapse and rehospitalization. Numerous double-blind, placebo-controlled clinical trials can be cited to support this conclusion and have been the subject of several review articles." Kane, *supra*, 13 Schizophrenia Bull. at 143.⁷

It is important to emphasize that antipsychotics are not simply pharmacological alternatives to physical restraints, such as those at issue in *Youngberg v. Romeo*.

⁶ "[T]here is still no single substitute for neuroleptics for control of symptoms and prevention of relapse in the majority of chronic schizophrenic patients. Denying these patients the benefit of the neuroleptic action without offering any suitable alternative may be considered a clinical error." Jeste & Wyatt, *Changing Epidemiology of Tardive Dyskinesia: An Overview*, 138 Am. J. Psychiatry 297, 306 (1981) (footnote omitted).

⁷ See Berger, *Medical Treatment of Mental Illness*, 200 Science 974 (1978); Romano, *On the Nature of Schizophrenia: Changes in the Observer as Well as the Observed (1932-1977)*, 3 Schizophrenia Bull. 532 (1977).

Rather, their chemical effect is to clear the hallucinations and delusions that are produced by psychosis, thus facilitating long-term stability and decreasing the need for extended hospitalization.⁸ Restraints, by contrast, are used to immobilize an agitated person in order to prevent him from inflicting physical harm on himself or others. Typically, they have only a short-term effect and, indeed, can have serious physical side effects when used with a resisting patient.⁹ In short, medication is directly therapeutic in both the short and long term and, in no event, readily interchangeable with physical restraints.

Nor does it make any sense to characterize antipsychotics as "mental restraints," or to regard them, as the court below has, as "highly intrusive" because they "are by intention mind altering." *Harper, supra*, Pet. App. at A-5. There is simply no clinical basis for a concern that antipsychotics impinge on protected interests in speech or thought. To the contrary, the documented effect of antipsychotic medication on the severely mentally ill is to further traditional concerns for freedom of speech and thought by enhancing the mentally ill person's ability to concentrate, to read, to learn, and to communicate. According to one study of the clinical effects of antipsychotic medication on "mentation," "[t]he experimental data cannot be interpreted as being consistent with a view of these drugs as mind-altering, thought-inhibiting, or destructive of personality in a negative sense. In fact, the beneficial effects of the medication on

⁸ Appelbaum & Gutheil, *Rotting With Their Rights On*, 7 Bull. Am. Acad. Psychiatry & L. 306, 308 (1979). See Spohn, *et al.*, *Phenothiazine Effects on Psychological and Psychophysiological Dysfunction in Chronic Schizophrenics*, 34 Archives Gen. Psychiatry 633 (1977). The resulting decrease in distorted thinking increases a patient's potential for deriving long-term benefits from other, non-pharmacological treatment, such as psychotherapy or milieu therapy.

⁹ Physical restraints may nevertheless be medically indicated in certain circumstances. See APA, *Task Force Report 22: Seclusion and Restraint—The Psychiatric Uses* (1985).

complex aspects of mentation suggest that the opposite conclusion is true: the medications reinforce the most important aspects of mental functioning." Gutheil & Appelbaum, "Mind Control," "Synthetic Sanity," "Artificial Competence," and *Genuine Confusion: Legally Relevant Effects of Antipsychotic Medication*, 12 Hofstra L. Rev. 78, 119 (1983); see Appelbaum & Gutheil, *Rotting With Their Rights On*, 7 Bull. Am. Acad. Psychiatry & L. 306, 310 (1979); Spohn, *et al.*, *Phenothiazine Effects on Psychological and Psychophysiological Dysfunction in Chronic Schizophrenics*, 34 Archives Gen. Psychiatry 633 (1977); Meadow, *et al.*, *Effects of Phenothiazines on Anxiety and Cognition in Schizophrenia*, 36 Diseases Nervous Sys. 203, 207-08 (1975).

The enormous contribution of antipsychotics to the treatment and cure of psychoses can be discerned in the dramatic reduction of state hospital populations over the past three decades.¹⁰ Further, the use of psychotropic drug therapy has enabled patients to be hospitalized for far shorter periods of time—reducing the median hospital stay from forty-four days in 1971 to twenty-six days in 1976—and has shifted the primary locus of care from the hospital to community treatment programs.¹¹ There can be little doubt, moreover, that these medications have played a significant role in converting state

¹⁰ See Ozarin, *et al.*, *A Quarter Century of Psychiatric Care, 1950-1974: A Statistical Review*, 27 Hosp. & Community Psychiatry 515 (1976); Dep't Health Education & Welfare, *Mental Health Statistical Note #153: Provisional Patient Movement and Selective Administrative Data, State and County Mental Hospitals, Inpatient Services by State: United States 1976* (Aug. 1979).

¹¹ See Klerman, *National Trends in Hospitalization*, 30 Hosp. & Community Psychiatry 110, 111-12 (1979); May, *et al.*, *Schizophrenia: A Follow-up Study of the Results of Five Forms of Treatment*, 38 Archives Gen. Psychiatry 776, 783 (1981) ("drug therapy given to hospitalized first-admission schizophrenic patients reduced the length of the initial hospital stay; the advantage so gained persisted in terms of days in the hospital and readmissions for at least four years from the first admission and three years from the first release").

hospitals from what were often custodial settings into constructive therapeutic environments.

The efficacy of antipsychotic medication, and the absence in the majority of cases of *any* feasible therapeutic alternatives, is well illustrated by the circumstances of Harper himself. The record below reflects the fact that Harper has been successfully treated in the past with antipsychotics, suffering no lasting side effects from their use. Findings of Fact, *supra*, Pet. App. at B-8. By contrast, as the trial court noted, Harper's tendency towards assaultive behavior, which his doctors have attributed to his mental disease, increased when he did not take his medications. See *id.* at B-5. On at least one occasion, the consequences of discontinuing medication were dramatic: upon ceasing medication following his 1983 transfer out of SOC, "his condition deteriorated, he decompensated, and [within 40 days] he was returned to SOC." *Id.* at B-6.

To be sure, psychotropic medication may cause unwanted side effects. Most of these, however, may be readily controlled by lowering dosages or, as in Harper's case, by adding another medication; these side effects ordinarily cease when antipsychotics are discontinued. See R. Baldessarini, *Chemotherapy in Psychiatry* 44-46 (rev. ed. 1985); APA, *Task Force Report 18: Tardive Dyskinesia* 13-19 (1980); see Harper, *supra*, Pet. App. at A-5 n.4. Like many critics, the Harper Court focused on one particularly serious side effect known as tardive dyskinesia, a condition characterized by involuntary or semi-involuntary tic-like movements, generally of the tongue, facial, and neck muscles or of the extremities. R. Baldessarini, *supra*, at 46. Tardive dyskinesia merits real concern and has, as a result, received significant scientific attention. See APA, *Task Force Report 18, supra*. Yet while Harper describes tardive dyskinesia as "severe," "potentially permanent," and "irreversible," Pet. App. at A-5, accurate clinical data reveal a different picture.

Among patients who develop tardive dyskinesia, the condition is most often mild. See APA, *Task Force Report 18, supra*, at 45.¹² The condition's symptoms range among patients from being barely noticeable to being uncomfortable and unattractive. See Jeste & Wyatt, *Changing Epidemiology of Tardive Dyskinesia: An Overview*, 138 Am. J. Psychiatry 297 (1981). Tardive dyskinesia is not generally progressive even when the antipsychotics are continued after the condition develops. Kane, *supra*, 13 Schizophrenia Bull. at 150. While the condition can persist after cessation of medication, its milder forms often abate when medication is reduced or discontinued. Jeste & Wyatt, *In Search of Treatment for Tardive Dyskinesia: Review of the Literature*, 5 Schizophrenia Bull. 251, 269, 275 (1979); see also Jeste & Wyatt, *Therapeutic Strategies Against Tardive Dyskinesia*, 39 Archives Gen. Psychiatry 803, 812 (1982); Yagi & Itoh, *Follow-Up Study of 11 Patients with Potentially Reversible Tardive Dyskinesia*, 44 Am. J. Psychiatry 1496, 1496, 1498 (1987). In any event, proper medical monitoring can certainly reduce, if not arrest, the development of more serious forms of tardive dyskinesia. See APA, *Task Force Report 18, supra*, at 137-53; Jus, *et al.*, *Long-Term Treatment of Tardive Dyskinesia*, 40 J. Clinical Psychiatry 72, 75-77 (1979).

Significantly, most persons treated with antipsychotics do not develop tardive dyskinesia, just as Harper himself had not at the time his medication was discontinued. The most precise estimates available suggest that 10 to

¹² According to studies reviewed by the APA Task Force, 60 percent of all tardive dyskinesia is mild or minimal in effect; 30 percent is moderate, and only about 10 percent may be characterized as severe. The Task Force concluded: "The wide range of severity illustrated in these several studies indicates the potentially misleading conclusions that might be drawn from epidemiologic surveys in which global prevalence rates typically obscure the relative infrequency of severe and disabling abnormalities and may incorrectly suggest a specter of grotesque incurable dyskinesias in large numbers of patients treated with antipsychotic drugs." APA, *Task Force Report 18, supra*, at 45-47 (emphasis in original).

20 percent of patients treated with antipsychotics for more than a year exhibit some manifestation of tardive dyskinesia. See APA, *Task Force Report 18, supra*, at 43-44, 171.¹³ While there are some exceptions, it is extremely rare for tardive dyskinesia to result from short-term usage of the drugs.

We do not seek to diminish the gravity of this uncomfortable and potentially serious side effect of antipsychotic medication. But recognition of the possible costs of such treatment must take account of the clinical fact that "the overwhelming preponderance of data supports a high benefit/risk ratio for these medications and a safety record commensurate with other powerful pharmacologic agents." Appelbaum & Gutheil, *Rotting With Their Rights On, supra*, 7 Bull. Am. Acad. Psychiatry & L. at 307 (footnote omitted); see also, Baldessarini & Lipinski, *Risks of Antipsychotic Drugs Overemphasized*, 305 New Eng. J. Med. 588 (1981) ("[T]he use of available antipsychotic agents continues to be the cornerstone of management of these serious and disabling mental illnesses."). Veliz & James, *Medicine Court: Rogers in Practice*, 144 Am. J. Psychiatry 62, 63 (1987) (antipsychotics are "the single most effective treatment for psychosis").

B. The Due Process Clause of the Fourteenth Amendment Secures a Right to the Exercise of Professional Judgment in the Administration of Psychiatric Care.

The involuntary administration of psychotropic drugs to prisoners undeniably "implicate[s]" constitutionally protected liberty interests. *Mills v. Rogers, supra*, 457 U.S. at 299 n.16. Because of its limited understanding of the role of psychotropic medication, however, the *Harper* Court mistakenly cast the issue before it as a

¹³ See also Gardos & Cole, *Overview: Public Health Issues in Tardive Dyskinesia*, 137 Am. J. Psychiatry 776, 776-77 (1980) (4-5 percent of schizophrenic patients developed tardive dyskinesia within one year of hospitalization, even though many had previously used antipsychotics for prolonged periods).

simple instance of individual autonomy pitted against incompatible and potentially harmful state action. Presuming that psychotropic medications are harmful, ignoring their unquestioned therapeutic benefits, and refusing even to acknowledge the unfortunate consequences of a refusal to be treated, the *Harper* Court elevated Harper's legitimate interest in avoiding *unwarranted* treatment into a constitutional right to refuse treatment that is *unwelcome*. While the Constitution must protect the former, it cannot be stretched to accommodate the latter.

1. The Individual Interest in Appropriate Care.

Because of the potential side effects, a mentally ill prisoner does have a legitimate interest in protecting against the unnecessary or inappropriate use of medication—for example, in unduly high dosages, without regard to potential side effects, or as a means of restraint. See *Jones v. United States*, 463 U.S. 354, 385 n.19 (1983) (Brennan, J., dissenting). Concern for the proper use of medication is thus an interest that warrants significant recognition in the constitutional balance. But there is no substantial interest in refusing widely accepted and generally effective medication properly addressed to protecting the patient and others from harm, treating the patient's illness, and limiting the restraints on his or her liberty.

This Court's decision in *Youngberg, supra*, accurately comprehends the nature of the due process interest at stake in this case. *Youngberg* held that due process imposes upon a state maintaining a psychiatric institution an affirmative duty "to provide minimally adequate or reasonable training to ensure [patients'] safety and freedom from undue restraint." *Youngberg, supra*, 457 U.S. at 319; see *DeShaney v. Winnebago County Dep't of Social Services*, 109 S. Ct. 998, 1005 (1989). This duty not only defines the state's obligation towards a patient in need of care, but it also gives rise in an individual pa-

tient to a liberty interest in training. *Youngberg, supra*, 457 U.S. at 317-18.

Psychotropic medication warrants the same constitutional analysis. Like appropriate training, neuroleptics enable a psychotic prisoner to achieve the greatest security and freedom available within the terms of his or her penal confinement. Significantly, however, just as *Youngberg's* habilitation interest does not generate a corresponding constitutional "right" in an individual to demand or to refuse any particular mode of training,¹⁴ a prisoner enjoys no constitutional right to demand or to refuse antipsychotic medication. Rather, *Youngberg* accords an institutionalized person the substantive right to have decisions about his or her treatment program made by an appropriate professional decisionmaker according to and consistent with accepted professional judgment, practice, or standards. See *id.*, 457 U.S. at 322-23. In this way, *Youngberg* ensures that one confined within a state institution receives such treatment as can facilitate security and freedom from restraint while preserving his or her due process protection from "the arbitrary exercise of the powers of government." *Daniels v. Williams*, 474 U.S. 327, 331 (1986) (quoting *Hurtado v. California*, 110 U.S. 516, 527 (1884)); see *DeShaney v. Winnebago County Dep't of Social Services, supra*, 109 S.Ct. at 1003.

By its terms, the professional judgment standard is properly tailored to the patient's legitimate concern in avoiding the inappropriate use of medication. Reliance on such a standard, however, does not render superfluous either a patient's preferences or the risk of potential side effects—the interests singled out by the *Harper* Court as the basis for taking treatment decisions out of the hands

¹⁴ See *Jones v. United States, supra*, 463 U.S. at 385 (Brennan, J., dissenting). While recognizing an affirmative right to training that reflects professional decisionmaking, *Youngberg* limited an involuntary committee's due process entitlement to freedom from unreasonable restraint to "a guarantee that professional medical judgment be exercised." *Ibid.*

of professionals and making them, instead, the subject of each prisoner's preferences. Rather, a clinical decision to administer antipsychotic medication—whether or not the patient consents and whether or not he or she is deemed competent—should take into account the patient's wishes, the therapeutic implications of involuntary treatment, the individualized risk of side effects, the relative risks and benefits of other potential treatments, if any, and, where called for, the opinions of other professionals. See *Rennie v. Klein, supra*, 720 F.2d at 272 (Adams, J., concurring); *id.* at 273-74 (Seitz, C.J., concurring); Appelbaum & Gutheil, *Clinical Aspects of Treatment Refusal*, 23 *Comprehensive Psychiatry* 560 (1982). This calculus thus fully comprehends the due process interest of the individual with respect to antipsychotic medication.

2. The Government's Interest in Providing Treatment.

At the same time, the professional judgment standard also accommodates "the legitimate interests of the State," which in large measure coincide with the patient's interest in receiving appropriate treatment. *Youngberg, supra*, 457 U.S. at 321. When an incarcerated schizophrenic needs antipsychotic medication, the state acquires an interest in relieving that prisoner's psychosis that coincides precisely with his or her interest in relief. See *Addington v. Texas, supra*, 441 U.S. at 426 ("state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves"); see also, *O'Connor v. Donaldson, supra*, 422 U.S. at 575.¹⁵

¹⁵ This interest becomes particularly compelling when considered in light of *Estelle v. Gamble*, 429 U.S. 97 (1976), which imposes upon a state an affirmative duty under the Eighth Amendment to provide medical care to those whom it incarcerates. See also *DeShaney, supra*, 109 S.Ct. at 1005 (footnote omitted) (characterizing *Youngberg* as extending *Estelle's* affirmative duty "beyond the Eighth Amendment setting").

Closely related to these purely therapeutic concerns stands the state's interest, here recognized as the SOC's predominant purpose, in stabilizing and improving a psychotic inmate's medical condition so as to enable a transfer from a mental health unit to an appropriate prison setting to which the inmate has been sentenced. Indeed, Harper's own history reveals that proper and timely treatment of mental illness may even help lead to parole. As Harper's history also proves, however, subsequent refusal of needed medication can result in re-hospitalization or reincarceration. See Schultz, *The Boston State Hospital Case: A Conflict of Civil Liberties and True Liberalism*, 139 Am. J. Psychiatry 183, 184 (1982); Shavill, *Patients' Rights v. Patients' Needs: The Right to Refuse Treatment in Colorado*, 58 Den. U. L. Rev. 567, 602-05 (1981). Extended or repeated institutionalization imposes heavy fiscal burdens that a state may properly wish to avoid.

Independent of an individual prisoner's clinical needs, the state possesses an interest in preventing the serious disruption that psychotic patients can cause within a hospital or prison environment. Untreated, a mentally ill person may exhibit unpredictable, bizarre, and inappropriate behavior. Like Harper himself, many psychotic individuals are often assaultive, placing themselves or others in danger of serious physical harm. Moreover, even when hospitals or prisons have facilities in which to segregate mentally ill persons from the general population, one unmedicated psychotic inmate can severely disturb the entire therapeutic milieu of the unit, thus interfering substantially with the treatment and progress of other inmates segregated for psychiatric or other medical care.¹⁶ An unmedicated psychotic's disruptive behavior

¹⁶ For psychiatric patients in particular, environment constitutes an important component in a total treatment program. See generally, Raskin, *Milieu Therapy Reexamined*, 17 Comprehensive Psychiatry 695 (1976); Abroma, *Defining Milieu Therapy*, 21 Archives Gen. Psychiatry 553 (1969). It can be extremely frightening to live in close quarters with unmedicated psychotic persons who are agi-

may also undermine various collective treatment practices, such as group therapy, milieu therapy, and recreational and vocational therapy. See Kibel, *A Conceptual Model for Short-Term Inpatient Group Psychotherapy*, 138 Am. J. Psychiatry 74 (1981).¹⁷

In sum, the *Youngberg* standard fairly balances the relevant interests of the state and the individual, and focuses the due process inquiry where it belongs: on the common ground where the patient's interest in proper treatment coincides with the state's interest in providing such care.¹⁸ By contrast, the concept of patient preference, the cornerstone of Harper's constitutional analysis, is essentially irrelevant to a due process inquiry. The individual's basic due process right to be free from

tated and acting out. Such a milieu does little to calm a patient or to engender confidence that he or she, unlike the manifestly disturbed unmedicated patient, is likely to be cured. See Amarasingham, *Social and Cultural Perspectives on Medication Refusal*, 137 Am. J. Psychiatry 353 (1980). At the same time, one prisoner's medication refusal may encourage others to follow suit. Gill, "Side Effects of a Right to Refuse Treatment Lawsuit: The Boston State Hospital Experience," in *Refusing Treatment in Mental Institutions—Values in Conflict* 83 (Doudera & Swazy, eds. 1982).

¹⁷ Maintaining a significant number of unmedicated patients may impose considerable burdens on the staff in caring for the refusing prisoner and others whose treatment programs break down. These burdens, in turn, carry unfortunate consequences for recruiting and keeping staff of a consistently high quality. In Massachusetts, for example, after a district court mandated a judicial review procedure much like Harper's, see *Rogers v. Commissioner of Dep't of Mental Health*, 390 Mass. 489 (1983), staff attrition at a state psychiatric hospital doubled and a medical school withdrew its residency program. See Schultz, *supra*, 139 Am. J. Psychiatry at 185.

¹⁸ Indeed, in the years since *Youngberg*, every Court of Appeals to address the question has squarely held that the "professional judgment" standard fairly exhausts the constitutional interest in refusing treatment with antipsychotic medication. *United States v. Charters*, *supra*, 863 F.2d at 314; *Dautremont v. Broadlawns Hosp.*, 827 F.2d 291, 300 (8th Cir. 1987); *Rennie v. Klein*, *supra*, 720 F.2d at 269; *Johnson v. Silvers*, 742 F.2d 823, 825 (4th Cir. 1984); *Project Release v. Prevost*, *supra*, 722 F.2d at 980; see also *United States v. Bryant*, 670 F. Supp. 840, 844 (D.Minn. 1987).

"arbitrary governmental action," *Youngberg, supra*, 457 U.S. at 316, is the same regardless of whether the patient is legally or functionally competent, or even whether he favors or opposes the use of particular medications. By focusing exclusively on a patient's preferences, or, absent that, substituted judgment, the court at once deprecates both the state's interest in providing treatment that is appropriate and the patient's legitimate interest in avoiding treatment that is not.

C. No Judicial Hearing Is Constitutionally Compelled Before a Prisoner Is Administered Psychotropic Medication.

The nature of the liberty interest affected by a particular state action defines what process is due to protect that interest. See *Morrissey v. Brewer*, 408 U.S. 471, 481 (1972). Having miscast the due process debate in terms of individual autonomy, rather than in the "essentially medical" context of proper diagnosis and treatment, *Vitek v. Jones, supra*, 445 U.S. at 495, it comes as no surprise that the *Harper* Court fashioned a procedure that places the prisoner's real or presumed preferences at the center of an elaborate, pre-treatment judicial hearing at which the state has the burden of proving a "compelling state interest" sufficient to offset the prisoner's so-called "right to refuse." When the risks and benefits of the drugs are properly understood, however, and the appropriate substantive liberty interest identified, judicial hearings prove not only unnecessary, but counter-productive.

We recognize, of course, that under *Vitek v. Jones, supra*, the decision "to classify [a prisoner] as mentally ill and to subject him to involuntary psychiatric treatment" requires the "additional due process protections" that were afforded to Harper by the SOC procedures. 445 U.S. at 494. Thus, under the SOC medication policy, the decision to administer medication must incorporate a diagnosis that the prisoner stands in need of psychiatric care. Findings of Fact, *supra*, Pet. App. at B-3. Specifically, a prisoner may be involuntarily medicated with

antipsychotics only after a determination that he suffers from a mental disorder requiring psychiatric treatment. *Ibid.*

Due process will tolerate no less. At the same time, *Vitek* makes clear that it requires no more. Once the threshold medical decision to treat has been properly reached and reviewed, a psychiatrist's judgment to treat a mentally ill prisoner by means of neuroleptic medication—or, for that matter, by non-drug therapy or any other conventional form of treatment—does not compel additional process to scrutinize each treatment decision as the inmate's condition evolves. To the contrary, the procedures mandated by *Vitek* protect the prisoner not merely from the stigmatizing consequences of the initial transfer to a mental institution, but also from the potential harm of being subjected to "involuntary psychiatric treatment," 445 U.S. at 494, that may well, as in Harper's case, prove to be "unwelcome," *id.* at 495. Under the standards set forth in *Vitek*, accordingly, procedural due process is satisfied where, as here, the diagnosis and treatment of a prisoner's mental illness is committed to a psychiatric professional so long as the propriety of the initial decision to transfer for psychiatric treatment is subject to review by an independent decisionmaker for its consistency with professional judgment, practice, and standards. *Youngberg, supra*, 457 U.S. at 322-23; see *Vitek v. Jones, supra*, 445 U.S. at 493.

There is nothing novel about this conclusion. *Vitek* rests on a determination that exposure to appropriate psychiatric treatment—whether on a voluntary basis or involuntarily if necessary—is implicit in the diagnosis of mental illness requiring care in a mental, as opposed to penal, facility. As such, *Vitek* does no more than to apply the general rule that where the initial deprivation of liberty is proper, the government is also authorized "to employ devices that are calculated to effectuate [the purposes of] this detention." *Bell v. Wolfish*, 441 U.S. 520, 537 (1979). In the context of involuntary civil commitment—of which *Vitek* is the penal analogue—this

Court has frequently recognized that confinement to a mental facility necessarily entails "compelled treatment," *Addington v. Texas*, *supra*, 441 U.S. at 427, or "compulsory [psychiatric] treatment" *Humphrey v. Cady*, 405 U.S. 504, 508 (1972). Indeed, any other result would be particularly pointless in a penal setting; since a prisoner is already confined, the only conceivable purpose for the transfer to a psychiatric care facility—and the point of safeguarding this determination through the procedural protections required by *Vitek*—is to provide medically appropriate treatment. Since the SOC procedures reasonably ensure the correctness not only of the diagnosis itself, but also of the decision to treat with antipsychotic medication, the requirements of due process are clearly met.

These settled principles notwithstanding, the *Harper* Court concluded that "the highly intrusive nature of antipsychotic drug treatment warrants greater protections than those necessary to protect the interests at issue in *Vitek*." *Harper*, *supra*, Pet. App. at A-8 (footnote omitted). As we have already established, however, the supposed intrusions of antipsychotic drug therapy are largely illusory; there is simply no factual medical basis nor any principled constitutional reason for distinguishing treatment with antipsychotic medication from the "involuntary psychiatric treatment" contemplated within the procedures approved in *Vitek*.¹⁹

¹⁹ Thus, in the civil commitment context, where the need for involuntary hospitalization is determined at a judicial commitment proceeding, we would question the need for any further proceedings before medication may be administered involuntarily. If further proceedings are found to be necessary, the independent administrative review embodied in the SOC procedures is plainly sufficient. We do not mean to suggest, however, that, in the civil commitment setting, similar procedures are required as a matter of due process. Unlike a prisoner, a civilly committed patient is being confined specifically for the purpose of receiving psychiatric care. This distinction renders the *Vitek* due process requirements—which are necessary because the transfer to a mental hospital implicates additional liberty interests—inapplicable to civil commitment cases.

Moreover, even if the potential for serious side effects—and the resulting individual interest in avoiding unnecessary or inappropriate medication—would justify special constitutional scrutiny, judicial hearings would contribute little. As this Court recognized in *Vitek*, "whether or not to transfer an inmate to a mental hospital for treatment involves a question that is essentially medical," and "turns on the meaning of the facts which must be interpreted by expert psychiatrists and psychologists." 445 U.S. at 495 (quoting *Addington v. Texas*, *supra*, 441 U.S. at 429). And, as with the issues raised by civil commitment, "'neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments.'" *Parham v. J.R.*, *supra*, 442 U.S. at 609 (quoting *In re Roger S.*, 19 Cal.3d 921, 942, 141 Cal. Rptr. 298, 311 (1977) (Clark, J., dissenting)).²⁰

While the potential benefits of judicial review here are thus speculative at best, the costs are clear. Resort to

²⁰ Even under the *Harper* standards, the question of whether a countervailing state interest exists calls for medical, rather than legal judgments. Thus, the state must prove "essentially medical" facts such as whether drugs would be necessary and effective, and whether the patient's condition, if untreated, would pose a risk of suicide or a threat to life. *Harper*, *supra*, Pet. App. at A-10. Even if the court is correct that these are the appropriate standards, it is impossible to see how a judge could be viewed as better suited to making the required determinations than independent medical professionals.

Every one of the courts of appeal to consider the issue since *Youngberg* has recognized that, wholly apart from the costs of judicial review, independent administrative review is inherently preferable. *United States v. Charters*, *supra*, 863 F.2d at 305-08; *Project Release v. Prevost*, *supra*, 722 F.2d at 981; *Rennie v. Klein*, *supra*, 720 F.2d at 270 & 270 n.9; *Johnson v. Silvers*, 742 F.2d 823 (4th Cir. 1984). These courts have consistently recognized that, as the *en banc* Fourth Circuit put it in *Charters*, the decision to medicate is "based upon specialized scientific expertise," 863 F.2d at 308, and is best invested in an administrative scheme that places the "responsibility for making the base-line governmental decision to medicate in the appropriate medical personnel of the custodial institution." *Id.* at 307.

judicial hearings will, as a general matter, occasion "unnecessary intrusion into either medical or correctional judgments," that could be avoided "by providing that the independent decisionmaker conducting the transfer hearing need not come from outside the prison or hospital administration." *Vitek v. Jones*, *supra*, 445 U.S. at 496 (citation omitted). Moreover, judicial hearings would substantially erode the deference to the informed decisions of medical professionals that underlies the *Youngberg* standard. See *Youngberg*, *supra*, 457 U.S. at 322 & 322-23 n.29; cf. *Parham v. J.R.*, *supra*, 442 U.S. at 608 n.16.

In addition, as a practical matter, an increase in judicial hearings will necessarily mean "that mental health professionals will be diverted even more from the treatment of patients in order to travel to and participate in—and wait for—what could be hundreds—or even thousands—of hearings each year. Obviously, the cost of these procedures would come from the public mon[ies] the legislature intended for mental health care." *Parham v. J.R.*, *supra*, 442 U.S. at 606. Experience proves this point. In *Rogers v. Commissioner of Dep't of Mental Health*, 390 Mass. 489 (1983), on remand from this Court, see *Mills v. Rogers*, *supra*, the Massachusetts Supreme Judicial Court, relying on state law, fashioned a procedure, virtually identical to the *Harper* regime, by which state courts must review a physician's recommendation that antipsychotic medication be administered over the objection of an institutionalized patient. During one eighteen-month period, the Massachusetts Department of Mental Health petitioned the courts for a "Rogers" order permitting antipsychotic drug treatment in 2273 cases, at a rate of 126 petitions per month. Massachusetts Dep't of Mental Health Legal Office, *Report on the Dep't of Mental Health's Implementation of the Supreme Judicial Court's Decision in Rogers v. Com-*

missioner, at 22 (Sept. 30, 1988) ["DMH Memo"].²¹ Of that number, 2216 were pursued to decision. Among the petitions concerning persons who refused medication, 98.6 percent were granted; only 1.4 percent were denied. *Id.* at 26.

The cost of overturning the initial treatment recommendation for that 1.4 percent proved extraordinarily high. During the same eighteen-month period, Department of Mental Health attorneys logged at least 10,500 hours in preparing and litigating treatment petitions. That figure translates into 28 attorney-hours each working day. DMH Memo at 34.²² Similar demands were made on clinical staff. Thus, 4800 clinical staff hours were spent directly on *Rogers* petitions during the period studied, representing an average of eighteen clinical staff hours each working day. DMH Memo at 35.²³

Aside from the sheer administrative burden they impose, the *Harper* procedures build in an inordinate delay between diagnosis of mental illness and treatment for that condition. In Massachusetts, judicial review procedures similar to *Harper's* add months to the interim between diagnosis and treatment. According to several studies, the lapse between the filing of a petition and the date of a court hearing averages 4.5 months. Veliz & James, *supra*, 144 Am. J. Psychiatry at 63; see also, DMH Memo at

²¹ This number reflects only those petitions concerning a patient or other client of a Department facility. It does not reflect the mass of requests filed on behalf of private hospitals or skilled nursing facilities. DMH Memo at 22.

²² These statistics do not reflect time spent by Department paralegals. An estimated 3000 hours of paralegal time were expended in litigating *Rogers* petitions. That represents eleven and one-half paralegal hours each working day. DMH Memo at 36.

²³ These findings confirm an earlier evaluation of the Massachusetts program that found the judicial hearings to be "extremely time-consuming and cumbersome. They require an enormous investment in professional time (many hours of work for at least three lawyers, a psychiatrist, and a court) for each case." Veliz & James, *supra*, 144 Am. J. Psychiatry at 62.

31-32 (two to four month delay routine even where patient has consented to treatment). The penal setting of this case creates a particularly urgent concern that unproductive delay be avoided. Permitting a psychotic prisoner to remain unmedicated for months within the general prison population presents a very real danger of violent confrontations resulting in serious physical injury to that prisoner, to other inmates, or to prison officials.²⁴

Further, it cannot be overemphasized that antipsychotic medication is prescribed to treat the most serious of psychiatric disorders. Even in those cases that could not be described as emergencies, a two to four month delay in administering treatment can cause harmful and irreversible deterioration of a prisoner's mental condition.²⁵ Due

²⁴ The alternative of unmedicated administrative segregation for a psychotic prisoner alleviates the threat his or her illness may present to others, but it cannot relieve and may likely aggravate the dysphoria that many psychotics experience before receiving proper treatment. In addition to subjecting the prisoner to the often intense discomfort of untreated psychosis, such a transfer to solitary confinement would likely deprive a prisoner of a significant measure of liberty enjoyed among the general population. See *Vitek, supra*, 445 U.S. at 495-96. Although this Court has held that no process is constitutionally due before a transfer to administrative segregation may be ordered, *Hewitt v. Helms*, 482 U.S. 755 (1987), the liberty deprivation associated with such confinement should nonetheless weigh against its adoption as an acceptable alternative to timely psychiatric treatment by therapeutic means.

²⁵ See Gutheil, *et al.*, *Legal Guardianship in Drug Refusal: An Illusory Solution*, 137 Am. J. Psychiatry 347 (1980).

The risks of delay are particularly acute in view of the fact that *Harper* incorporates no provision for treating patients on an emergency basis. Although the decision lists the preservation of life, the protection of third parties' interests, and the prevention of suicide as examples of overriding state interests, *Harper, supra*, Pet. App. at A-10, these must nevertheless be proven by "clear, cogent, and convincing evidence," *id.* at A-11, at a judicial hearing before any medication may be administered. This limited exception is little more than an empty gesture. We are aware of no guidelines, whether imposed by a court, incorporated in a statute or adopted as regulations, that are similarly restrictive.

process does not compel a prisoner in need of care to endure so long a period of untreated psychosis for the sake of judicial participation in a medical decision.

CONCLUSION

The judgment of the Washington Supreme Court should be reversed.

Respectfully submitted,

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BRIEF

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INTEREST OF AMICI CURIAE *

The amici represent mental health providers from throughout the State of Washington. Some of the amici provide inpatient services, others treat patients on an outpatient basis, and some do both. These services are funded by governmental agencies, grants from charitable organizations, and fees paid by patients or their insurance companies. Whatever the variations in funding or format, all the amici share a common concern and conclusion: the *Harzer* decision already has had, and will continue to have, a distinctly detrimental impact on their ability to properly provide services to the mentally ill of Washington State.

Washington Community Mental Health Council is the umbrella organization for 50 community mental health centers located throughout the State of Washington. Their mission is to support and encourage the development of mental health services in Washington State.

Carondelet Psychiatric Care Center is a comprehensive mental health program providing both inpatient and outpatient services. Its primary service area is Benton and Franklin counties, but it also serves as the site for involuntary hospitalization for people from Walla Walla, Columbia, Adams, Garfield, Asotin, Klickitat, and Grant counties. Carondelet has a 32 bed inpatient unit for adolescents and adults, providing services to 800 inpatients yearly. Through its outpatient programs, Carondelet provides services to 700 people annually.

Central Washington Community Mental Health Center serves Kittitas and Yakima counties. Offering a comprehensive range of services through 30 programs, it serves 8,000 patients/clients annually. The Center has both outpatient and residential care programs for children and adults. Through its emergency crisis line it receives 3,000 calls per month. If someone refuses medication and cannot be admitted to a private hospital, a client of the Center must travel five hours to the State hospital.

* Consent to file this brief has been obtained from the parties.

Highline-West Seattle Community Mental Health Center is a large, comprehensive community mental health center providing services to King County. Services include adult day treatment and residential support programs, programs for the elderly, and family counseling programs. The Center operates a 30 bed inpatient unit for involuntarily hospitalized persons. This unit annually serves 700 patients, whose average length of stay is 12 days.

Kitsap Mental Health Services is the primary provider of mental health services for Kitsap County, which has approximately 165,000 residents. Through its ten programs Kitsap provides both inpatient and outpatient mental health services. Chosen by the Washington State legislature to serve as a model program for community based treatment for the involuntarily committed chronically mentally ill, Kitsap provides care to 325 involuntarily hospitalized inpatients each year and to 1,000 outpatients.

Sacred Heart Medical Center is a 615 bed acute care hospital located in Spokane which serves eastern Washington, northern Idaho, and western Montana. It has three units, with a total of 72 beds, providing inpatient psychiatric care to children, adolescents, and adults. Under contract with the State of Washington, the Center is the primary private provider of care to involuntarily hospitalized patients in eastern Washington. Sacred Heart provides care to approximately 1,700 psychiatric inpatients per year.

Southwest Washington Hospitals is a 325 bed hospital which serves the populations of Clark, Skamania, and Klickitat counties. These counties have a combined population of 350,000 people. The hospital has a 17 bed inpatient unit which provides care to 600 patients yearly. It also operates a crisis intervention service, which provides services to 1,000 people annually. Once the hospital turns away a patient who is refusing medication, it is a 2 1/2 hour drive to the nearest state mental hospital.

Spokane County Community Services Department is the governmental agency which disburses and manages funding of mental health services for Spokane County, which has 360,000 residents. Services are funded for children and adults, for

outpatients, and for those in need of involuntary treatment. Additionally, the Department funds the costs of involuntary commitment hearings in the Spokane County Superior Court.

Spokane Community Mental Health Center serves the mentally ill of Spokane County. It has 26 programs, including a residential treatment facility, as well as a wide variety of outpatient services. Serving 6,000 patients/clients per year, the Center answers 5,000 calls a month through its crisis hot line. The Center provides evaluation and court testimony for involuntarily detained persons in the Spokane area.

Yakima Valley Memorial Hospital is a 225 bed acute care hospital, with a 17 bed psychiatric inpatient unit. It serves as an evaluation and treatment facility, providing care to 475 psychiatric inpatient's each year, approximately 25% of whom are involuntarily committed. Yakima Valley serves the population in south central Washington.

SUMMARY OF ARGUMENT

The Washington Supreme Court, in a case which addressed the issue of what process is due a prisoner who is refusing antipsychotic medication, held that "the constitutional liberty interest in refusing . . . antipsychotic drug treatment survives criminal conviction *just as it survives civil involuntary commitment.*" *State of Washington v. Harper*, 110 Wn. 882 (1988) (emphasis added). Without argument before the court, and without any apparent understanding of the benefits or risks of antipsychotic medication, the court through dictum gave civil committees the right to a judicial hearing when they refuse antipsychotic medication. This decision, if permitted to stand, has had, and will continue to have, disastrous consequences for civil committees who need treatment, and for those mental health professionals who are responsible for providing for their care and treatment.

The Washington Supreme Court in *Harper* failed to consider the elaborate substantive and procedural due process protections afforded to individuals when civil commitment is sought. Before involuntary commitment of more than minimal duration can occur there must be a hearing, with representation by counsel,

at which it must be determined that the person suffers from a "mental disorder as a result of which he presents a likelihood of serious harm to himself or others or is gravely disabled" RCW § 71.05.020. Once confined, the expectation is that treatment will occur. For without treatment, there is no justification for the confinement.

For individuals with psychotic behavior, the only effective treatment is antipsychotic medications. These medications control the symptoms of the illness, so normal behavior can return. Once normalization occurs, discharge from the hospital quickly follows. If antipsychotic medications cannot be given, or are delayed, the liberty of the patient is restricted. Untreated patients are more likely to require physical restraints and seclusion. Delays in treatment result in longer confinement to the institution.

This Court, through its decisions in *Youngberg v. Romeo*, 457 U.S. 307 (1982), *Parham v. J.R.*, 442 U.S. 584 (1979), and *Addington v. Texas*, 441 U.S. 418 (1979), has recognized that the rights of the patient are not absolute. These rights must be counterbalanced with the goal of the state to provide needed treatment in an effective manner. The state should not be required to bear a tremendous administrative and financial burden to meet its responsibilities. Yet if the *Harper* decision is upheld, the burden on Washington State is heavy, with no indication that the rights of the patient will have been better protected.

The case law developed by this Court supports the proposition that when an involuntarily confined civil committee refuses treatment, his rights can be properly addressed by an independent medical decisionmaker. If the medical professional determines, based on professional judgment, that the refusal of antipsychotic medication should be overridden, that determination is to be presumed valid.

By requiring a judicial hearing to review a patient's refusal of antipsychotic medication, the Washington Supreme Court has provided the committee greater constitutional protection than the realities of the use of antipsychotic medication, the treatment needs of committees, and the informed medical decisionmaking of mental health professionals, justify. It does this in a manner

which is actually likely to result in restriction of the committee's liberty, rather than protection of it.

ARGUMENT

INTRODUCTION

Virtually every law student learns, very early on, one of the hoary aphorisms of the profession: hard cases make bad law. The Washington Supreme Court's decision in *State of Washington v. Harper*, 110 Wn.2d 873 (1988), provides fodder for a latter day variation on this legal saw: good intentions also can make bad law. For in an earnest effort to extend constitutionally grounded protection to prison inmates, the *Harper* court wound up inflicting harm upon mentally disabled civil committees desperately in need of medical help.

The *Harper* court accomplished this sorry result by means of a multi-step legal scenario. First, the court ruled that a resistant prisoner cannot be forced to take antipsychotic medication unless a court so orders. Second, the court, expanding upon its infusion of judges and legalisms into the complexities of psychiatric treatment and pharmacology, further held that to obtain such an order the state has the burden of proving that it has "a compelling state interest to administer antipsychotic drugs" and that "the administration of the drugs is both necessary and effective for furthering that interest." 110 Wn. 2d at 883. These standards, devised in a case dealing with convicted felons confined in a state penal institution, then thoughtlessly were carried over to civil committees—who were in no way before the court. The *Harper* panel achieved this transfer from the criminal context to the civil by asserting that "the constitutional liberty interest in refusing . . . antipsychotic drug treatment survives criminal conviction and incarceration *just as it survives civil involuntary commitment.*" 110 Wn.2d at 882 (emphasis added).

The *Harper* decision reflects a basic misunderstanding of the uses, risks, benefits and impact of antipsychotic medication. The Washington Supreme Court either ignored, or was unaware of, the fact that treatment is the only basis for assuring a committee's quick return to the community: indeed, if treated expeditiously and properly, a patient can be expected to have

an average hospitalization of less than three weeks. If untreated, however, the patient will languish in the institution, and may even deteriorate, with the ultimate result being a lengthened period of time before he can secure his freedom. Even worse, a permanent refusal to accept treatment may militate against the patient ever becoming well enough to be discharged.

Thus, the *Harper* ruling—by injecting delay in, and possibly even a bar to, effective treatment—hampers, to no good end, the ability of health care providers to provide mentally ill committees effective and timely treatment. Indeed, the perverse consequence of the *Harper* ruling is to condemn these men and women—people whose mental incapacities are so severe as to have warranted court-ordered civil commitment in the first place—to more, rather than less, suffering.

Surely, the Constitution, on which the *Harper* court grounded its decision, promises—and can provide—better prospects for the mentally ill and for mental health professionals seeking to meet their ethical duty to provide good medical care to the mentally ill.

I. THE CIVIL COMMITMENT PROCESS IN WASHINGTON PROVIDES EXTENSIVE PROCEDURAL GUARANTEES FOR THE COMMITTEE, AND IS DESIGNED TO FAIRLY DETERMINE THE EXISTENCE OF MENTAL ILLNESS SEVERE ENOUGH TO WARRANT INVOLUNTARY HOSPITALIZATION

A. The Washington Supreme Court Thoughtlessly and Without Substantiation Imposed Upon the Civil Commitment System an Inappropriate Burden

In the context of dealing with a claim by a state prison inmate, the *Harper* court enunciated a constitutional right to refuse antipsychotic medication on the part of civil committees. The court did so with an unsubstantiated, unanalyzed assertion that a right established in a case involving electro-convulsive therapy to refuse treatment, subject to an overriding court order,

was applicable vis-a-vis antipsychotic medication.¹ Thus, the court was using the claim before it, involving a prisoner, to erect through dictum a new right to refuse treatment within the context of civil commitment proceedings.² Moreover, it accomplished this result without even acknowledging, let alone discussing, the intricacies of the Washington civil commitment scheme or the relevance or aptness of such a right in that context. A description of that system discloses just how far afield the court roamed when it equated state prison inmates with civil committees.

B. The Washington Mental Health Statutory Scheme Carefully is Focused on the Issue of Severe Mental Incapacity

The Washington mental health statutory scheme is very precise in focusing on the critical issue of an individual's mental state. An individual may only be civilly committed if (1) as a result of a mental disorder (2) he "presents a likelihood of serious harm to others or himself or is gravely disabled" and if, further, (3) he refuses to voluntarily accept treatment. This carefully crafted language ensures against abuse, and confines commitment proceedings to a very narrow scope. The statutory definitions demonstrate how carefully the process is designed:

"Mental disorder" means any organic, mental, or emotional impairment which has substantial adverse effects on an

¹ The court claimed to be simply extending its earlier decision in *In re Schuoler*, 106 Wn.2d 500, 723 P.2d 1103 (1986), which mandated a judicial hearing before ECT (electro-convulsive therapy) could be initiated. The *Schuoler* decision was in part based on the Washington statutory scheme, which particularly singles out ECT as being a treatment which only may be administered if special conditions are met. RCW § 71.05.370(7). Although both antipsychotic medications and ECT are considered effective treatment modalities for severe forms of mental illness, antipsychotic medications are considered part of routine, ordinary care. In contrast, ECT is rarely used, when compared with antipsychotic medications, and can only be administered under a general anesthetic. American Psychiatric Association, *Task Force Report 14, Electro-convulsive Therapy* (1987).

² The court's sole cited support was *Large v. Superior Court*, 148 Ariz. 229, 714 P.2d 339 (1986). This case rested on the Arizona constitution, and dealt only with convicted prisoners.

individual's cognitive or volitional functions RCW § 71.05.020(2).

. . .

"Likelihood of serious harm" means either (a) a substantial risk that physical harm will be inflicted by an individual upon his own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on one's self, or (b) a substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm RCW § 71.05.020(3).

. . .

"Gravely disabled" means a condition in which a person as a result of mental disorder is in danger of serious physical harm resulting from a failure to provide for his essential human needs RCW § 71.05.020(1)

A progressive system of confinement is geared to these definitions. Initially, an individual required to submit to evaluation and treatment may be detained for no more than 72 hours, and only by judicial order. RCW § 71.05.150(1)(b). Additional confinement for a maximum of 14 days can occur if "involuntary intensive treatment" is needed. RCW § 71.05.230. At the 14-day hearing the detained person is accorded a panoply of procedural rights, including the opportunity to present evidence, to cross-examine witnesses, to remain silent, and to be represented by counsel. RCW § 71.05.250.

An individual may be detained for another 90 days beyond the 14-day intensive treatment period, but only if further rigorous procedural and substantive requisites, including the detainee's right to a jury trial, are satisfied. RCW § 71.05.310. At each of these hearings the state has the burden of establishing that the person meets the commitment standards set forth above, i.e., he is suffering a mental disorder and as a result is likely to pose serious harm, or he is gravely disabled. Additionally, he must be refusing voluntary treatment. RCW § 71.05.230, 320.

It belabors the obvious to assert that the commitment scheme in the state of Washington is one infused at every step with procedural and substantive protections for the detainee. Only the most severe state of mental disability will justify commitment. It is a court which orders the commitment, and it does so in the context of a procedure-laden system designed to protect the rights of the individual at risk.

The *Harper* court's disastrous dictum thus simply is off the mark, for no committee receives medical treatment—be it anti-psychotic drugs or other care—without his already having been adjudged in need of treatment by virtue of the very commitment order. And no order issues save as the end result of a careful, considered process protective of individual right. Indeed, the Washington statutory scheme provides more procedural protections than this Court mandated in *Parham v. J.R.*, 442 U.S. 584 (1979) (commitment of minors), and in *Vitek v. Jones*, 445 U.S. 480 (1980) (transfer of prisoners to mental hospital), and it requires the same burden of proof that the Court established for civil commitment hearings in *Addington v. Texas*, 441 U.S. 418 (1979).

II. THE STATE HAS A PROFOUND INTEREST IN TREATING PATIENTS

A. The State has Legitimate Interests at Stake

No one would seriously contend that an involuntarily committed person is divested of his constitutional rights when the institutional doors close behind him. By the same token, no one could seriously argue that the state has no cognizable interests also deserving of constitutional credence. After all, the state ultimately is concerned with assuring the health of its citizens, even those who are so mentally incapacitated that they are unable or unwilling to either admit their illness and/or accept treatment for it. Once confined, the patient must be provided appropriate medical care and psychiatric treatment by the state. See, e.g. *Estelle v. Gamble*, 429 U.S. 97 (1976); *Bowring v. Godwin*, 551 F.2d 44 (4th Cir. 1977). The state also must protect the patients "as well as others from violence." *Youngberg v. Romeo*, 457 U.S. 307, 320 (1982). Finally, the government legitimately is concerned with assuring that a patient is not released to the community

until he no longer poses a danger to himself and others. Brakel, S.J., Parry, J. & Weiner, B.A., *The Mentally Disabled and the Law* 589 (3rd ed. 1985).

B. Treatment is the Necessary Concomitant of the State's Exercise of its Authority to Involuntarily Commit

Since the seminal judicial ruling in *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1967), it has been recognized by numerous courts that treatment must accompany commitment. Indeed, confinement of the mentally ill without treatment would be unacceptable, amounting to no more than preventive detention. See Appelbaum, *The Right to Refuse Treatment with Antipsychotic Medications: Retrospect and Prospect*, 145 Am. J. Psychiatry 417 (1988).

As Justice Brennan observed in his concurring opinion in *Youngberg v. Romeo*, *supra*, at 326 (1982), "commitment without any 'treatment' whatsoever would not bear a reasonable relation to the purposes of the person's confinement." Judge Bazelon more emphatically expressed a like view in *Rouse*, asserting that "involuntary confinement without treatment is 'shocking.'" 373 F.2d at 455. This concept that treatment is expected when civil commitment occurs is so fundamental that it has become embedded in every state's mental health code. Brakel, Parry & Weiner, *supra*, at 334.

Ironically, if the Washington Supreme Court's decision in *Harper* is permitted to stand, the result may be the denial of care—and certainly a delay in its provision, at the least. This follows from the facts that under the ruling (1) treatment cannot be administered to a resistant committee without there first being a judicial hearing, and (2) in that hearing the state bears a very heavy burden of justification for the treatment proposed.

Perverseness is added to this irony by virtue of the fact that generally it is because of the very severity of his mental illness and the extent of his psychosis that the patient refuses treatment. See Schwartz, Vingiano & Perez, *Autonomy and the Right to Refuse Treatment: Patients' Attitudes After Involuntary Medication*, 39 Hosp. & Comm. Psychiatry, 1049, 1052 (1988). Indeed,

most patients who refuse medication deny that they are ill, although it is quite clear to professionals that they indeed are just that. Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 Am. J. of Psychiatry 340 (1980); Miller, et. al., *The Impact of the Right to Refuse Treatment in a Forensic Patient Population*, Bull of AAPL (forthcoming 1989); Veliz & James, *Medicine Court: Rogers in Practice*, 144 Am. J. Psychiatry 62 (1987).

Requiring a judicial hearing whenever an involuntarily committed patient refuses effective treatment—i.e., treatment which skilled professionals have determined is in his or her best interest—ignores the fact that the very premise underlying the decision by the court to commit is the expectation that commitment will enable treatment to be provided. That is what the civil commitment scheme is all about, as stated in the expression of legislative intent set forth in the Washington statutory scheme: "The provisions of this chapter are intended by the legislature: . . . (2) To provide prompt evaluation and short term treatment of persons with serious mental disorders. . . ." RCW § 71.05.010.

Moreover, the whole civil commitment scheme is grounded on the notion that something is being done to a resistant individual. After all, there is certainly nothing barring an individual from voluntarily undergoing psychiatric treatment. By definition, then, an involuntary committee is an individual who has been judicially determined to be in need of treatment and who is unwilling to accept it. "Nonconsensual treatment is what involuntary commitment is all about." *Stensvad v. Reivitz*, 601 F. Supp. 128, 131 (W.D. Wisc. 1985). To contemplate, as the *Harper* Court's dictum allows, that a committee can only be treated if another judicial determination is made confounds the very goal of the initial commitment determination, i.e., treatment for individuals who need, but refuse, it.

C. Antipsychotic Medication is Required to Treat Serious Mental Illness

During the past three decades there has been a revolution in the care of the mentally ill. With the introduction of antipsychotic medications in the 1950's large state institutions which had been little more than warehouses for the untreatable mentally

ill were able to become treatment centers. Medication made it possible to treat the symptoms of their illnesses, so that patients could return to living normal lives in their communities. The statistics strikingly record this medical revolution. In 1955 there were 559,000 men and women confined in state and county hospitals for the mentally ill; by 1980 the number had plummeted to 138,000, even as the United States population was soaring. Goldman, Adams & Taube, *Deinstitutionalization: The Data Demythologized*, 34 Hosp. & Comm. Psychiatry 129 (1983). Similarly, the average length of stay has been sharply reduced from years to less than a month. This revolution can only be compared to the revolution in medicine which occurred when antibiotics were introduced.

Understanding this medical miracle is central to determining the proper response to a patient's refusal to accept medication. For one must comprehend the basic, medically irrefutable fact that for most serious mental illnesses which cause psychotic behavior, antipsychotic medications are the only effective treatment. Antipsychotic drugs, for example, are the primary treatment modality for the treatment of schizophrenic illness. The medications "generally have a dramatic effect on the symptoms of schizophrenia (e.g. delusions, hallucinations, and thought disorders) within 4-6 weeks, although improvement may continue well after that interval." Kane, *Treatment of Schizophrenia*, 13 Schizophrenia Bull. 134, 142 (1987). Once the medications achieve control of psychotic symptoms, other treatment modalities, such as various psychotherapies, can then be introduced. However, the clinical data do not support "substituting any psychotherapeutic strategy for drug treatment on an indefinite basis." *Ibid.*

Antipsychotic medication also must be used for the long-term treatment of chronic psychosis. Maintenance dosages are effective in reducing the risk of psychotic relapse and rehospitalization. Jeste & Wyatt, *Changing Epidemiology of Tardive Dyskinesia: An Overview*, 138 Am. J. Psychiatry 297 (1981).

It is now well documented that the primary effect of antipsychotic medications on psychotic symptoms is a normalizing one. Gutheil & Appelbaum, "Mind Control", "Synthetic Sanity," "Artificial Competence," and *Genuine Confusion: Legally*

Relevant Effects of Antipsychotic Medication, 12 Hofstra L.R. 77, 118 (1983). In this article the authors, both of whom are psychiatrists, reviewed all the studies related to the use of antipsychotic medication and provided clinical evidence disputing many of the charges made in so called right-to-refuse-treatment cases against antipsychotic medication. Of greatest importance was their clinical documentation that these medications indeed are neither intrusive nor mind altering. Furthermore, Gutheil and Appelbaum's review of all the scientific studies lead them to the conclusion that antipsychotic medications have no effect on memory, and do not appear to have any effect on attention or perception, or psychomotor functioning. In sum, and as the authors emphasized, the effect of medication is to enable the patient to function as he would absent psychotic illness. *Id.* at 105-117.

Admittedly, these medications, whose efficacy is now well established, can have adverse side effects. Of primary concern is tardive dyskinesia, which involves involuntary movements of the tongue, face, neck, and extremities. American Psychiatric Association, *Task Force Report 18: Tardive Dyskinesia* (1980). Tardive dyskinesia begins with mild, subtle movements. These are not necessarily progressive. Moreover, frequently the patient is not even aware of his involuntary movements. What is more, tardive dyskinesia appears to have no impact on mentation or functioning. *Id.* at 109. Even so, for some individuals this syndrome can cause serious problems because it may dramatically affect appearance.

If detected in its early stages, tardive dyskinesia can be controlled by the reduction or discontinuation of medication. *Ibid.* See also American Psychiatric Association, *Task Force Report 18, supra*; Baldessarini, R., *Chemotherapy in Psychiatry* 43-44 (1977). Moreover, since tardive dyskinesia is almost always a complication that occurs only after prolonged use of antipsychotic medications, the risks occasioned by using these medications during the initial hospitalization, when antipsychotic medication is most critical to treatment, are minimal.

Ultimately, in considering the possibility of tardive dyskinesia, one must take into account the benefits of antipsychotic medications, as measured against their possible risks. As with

other drugs used to treat other serious medical illnesses, such as arthritis, high blood pressure, and congestive heart failure, there are some potential negative consequences. Still, there is no clinical evidence to dispute the medically verified fact that antipsychotic medications alleviate the symptoms of mental illness so that within a relatively short time the once severely ill patient can be discharged from institutional confinement. And they accomplish this more effectively than any known alternative can. Indeed, in most instances there are no effective alternatives. In sum, these medications indeed are the true liberators of the mentally ill.

This is not to say antipsychotic medications should be blithely used by untrained care providers. The use of medications requires the application of careful medical attention, tempered by clinical experience. But nowhere in the *Harper* opinion was it suggested that physicians do not act in what they professionally believe to be the patients' best medical interests. Nor was there any suggestion in *Harper* that the safeguards in place in the Washington civil commitment scheme are inadequate to protect from improper treatment a committee who is detained for treatment by virtue of a considered court order. Thus, the 'treatment' hearing required by the *Harper* court—a hearing created out of whole cloth, without any analysis—is simply unnecessary. It can also be counterproductive, as discussed in Section II D., *infra*.

D. Treatment With Antipsychotic Medication Enhances the Committee's Liberty

If antipsychotic medication is not permitted, or delays in treatment are necessitated by a pending judicial hearing, the patient's interests indeed will be compromised—in some instances to a very significant degree. The patient, for example, who refuses needed medication is more likely to have to be physically restrained because of his agitated state creating a risk that he will harm himself or others. Rodenhauser, Schwenker & Khamis, *Factors Related to Drug Treatment Refusal in a Forensic Hospital*, 38 Hosp. & Comm. Psychiatry 631 (1987). Restraint may involve straps limiting the movement of the limbs or a "posey," which entails a cloth device with straps being wrapped around the patient and then tied to the chair or bed occupied

by the individual. The patient who refuses medication also is more likely to require seclusion because of his agitated state, which may bring harm to the patient or others. Tardiff, K., *The Psychiatric Uses of Seclusion and Restraints* (1984). This involves isolation in a locked room which is empty save for a mat to sleep or sit on, and which has an observation window.

These unfortunate, but necessary, consequences of non-treatment can hardly be deemed to be less confining, or more protective of liberty, than antipsychotic medication, which can restore the individual to normality with relative promptness. After all, restraints and seclusion are restrictive. They impede movement and they hamper or even preclude interaction with others, including patients, staff, and visitors. Moreover, physical restraints are readily visible and so are humiliating evidence of the individual's sorry state. Surely, this humiliating, even degrading, situation—one unfortunately necessitated by the patient's disruptive and even destructive state—cannot be compared to the far more moderate, and moderating, use of medication.

Indeed, there can be said to be a duty incumbent upon the state to avert this situation by providing treatment so as to render unnecessary the need for restraints and seclusion. The Court's analysis in *Youngberg v. Romeo*, *supra*, which requires that minimally adequate training be afforded retarded individuals who are institutionalized by the state so as to ensure their safety and to enable their freedom from undue restraint, can support a comparable requirement here. Like training in *Youngberg*, treatment with efficacious medications can be seen as a duty imposed upon the state in the name of vindicating the patient's liberty interest.

In addition to the use of restraints and seclusion, sedatives may be used to control difficult patients. Baldessarini, *Current Status of Antidepressants: Clinical Pharmacology and Therapy*, 50 J. of Clinical Psychiatry 117 (1989). Of course, amici certainly do not deem sedation to be an effective treatment modality, nor do other mental health professionals. Unfortunately, the *Harper* court, by imposing a very serious barrier to the use of antipsychotic drugs, has forced treating professionals to rely on sedation as a necessary means for protecting patients and others.

Additionally, one cannot ignore the reality that delayed treatment results in much lengthier periods of hospitalization. The patient for whom treatment is postponed usually requires larger dosages of antipsychotic medication, for longer periods, to bring him to the point of being able to return to the community. McEvoy, Howe & Hogarty, *Differences in the Nature of Relapse and Subsequent Inpatient Course Between Medication Compliant and Noncompliant Schizophrenic Patients*, 172 J. of Nervous & Mental Diseases 412 (1984). Patients who receive treatment early on recover in a few weeks and are discharged with full freedom restored. Those who do not receive treatment have their right to refuse held intact, but at the cost of the loss of all other liberties as they stagnate or deteriorate as inpatients, indefinitely or permanently. Given no requirement for speedy judicial review, the former patients will be recovered and home before the latter even have had their day in court. Shaw, Brakel & Davis, *The Right of Mental Patients to Refuse Treatment: A Liberty That Confines?* J. of Am. Bar Assoc. (forthcoming 1989).

III. A COMMITTEE'S RIGHTS CAN BE PROTECTED BY AN INDEPENDENT NON-JUDICIAL MEDICAL REVIEW MECHANISM

A. Judicial Hearings Erect Unreasonable Barriers to Needed Treatment

Walter Harper, a prison inmate, successfully persuaded the Washington Supreme Court that he had a constitutionally protected right to refuse antipsychotic medication, which right could only be overridden by a court order, issued after a hearing in which the state bore a very heavy burden of proof. Whatever the possible merits of Harper's contentions within the prison context, and amici believe they are few, given the Department of Corrections' pre-*Harper* inmate-protective procedures, the *Harper* court completely failed to consider the far differing interests which pertain in considering civil committees' refusals to accept needed medication. What the court should have done—but did not do—was to employ a balancing test, taking into account both the committee's interests and those of the state.

Had the court engaged in such a balancing test, which is dictated by *Mathews v. Eldridge*, 424 U.S. 319 (1976), it would

have had to have properly concluded that a judicial 'treatment' hearing would seriously undercut the state's efforts to further the legitimate interests of both the state and the patient that are served by civil commitment. *Addington v. Texas*, 441 U.S. 430 (1979). For judicial hearings "erect an unreasonable barrier to needed medical treatment." *Id.* at 432.

Indeed, in each case since *Youngberg v. Romeo*, *supra*, in which the federal courts of appeals have addressed the question of whether someone who is mentally ill and confined by the state has a right to refuse treatment which can only be overridden by a judicial order following a judicial hearing, the courts have resoundingly concluded that review by medical decisionmakers, using their professional judgment, satisfies the constitutional interest of involuntarily confined people to refuse antipsychotic medication. See *United States v. Charters*, 863 F.2d 302 (4th Cir. 1988); *Dautremont v. Broadlawns Hospital*, 827 F.2d 291 (8th Cir. 1987); *Johnson v. Silvers*, 742 F.2d 823 (4th Cir. 1984); *Project Release v. Prevost*, 722 F.2d 960 (2nd Cir. 1983); *Rennie v. Klein*, 720 F.2d 266 (3rd Cir. 1983).

B. A Committee's Due Process Interests Are Protected By Virtue of Review by A Medical Professional

When a mentally ill patient refuses needed treatment, the question of whether his refusal should be overridden is essentially a medical one. *Vitek v. Jones*, *supra*, at 495 (1980); *Parham v. J.R.*, *supra*. In reaching a decision the medical professional relies on his professional expertise. His determination necessarily takes into account the individual's wishes, and the bases for his resistance to treatment. Necessarily, also, the professional utilizes a risk/benefit analysis gauging whether the benefits of the medication outweigh the possible detriment of imposing undesired treatment.

The data in this area reveal that most refusals are a function of the person's illness and do not reflect any underlying belief about mental illness or its treatment. The refusal of medication is usually not consistently held by the patient over time. Schwartz, Vingiano & Perez, *supra*, at 1052. The patients' transient treatment refusals "stand in sharp contrast to their stated wishes

to be hospitalized should they become ill in the future and to be involuntarily medicated if necessary." *Id.* at 1053.

The decisions to be made in a refusal of treatment case require the expertise of professionals. Neither judges nor administrative hearing officers are as qualified as are psychiatrists and psychologists to make these decisions. See *In re Roger S.*, 19 Cal.3d 921, 941, 569 P.2d 1286, 1299 (1977). Although due process requires a neutral and detached trier of fact, there is no requirement that the person be trained in the law or be a judge. See, e.g., *Parham v. J.R.*, *supra*, at 607; *Morrissey v. Brewer*, 408 U.S. 471, 489 (1972); *Goldberg v. Kelly*, 397 U.S. 254, 271 (1970).

There are now a number of jurisdictions in which a prior court hearing is a predicate to overriding a patient's refusal to accept medication. Massachusetts is one such jurisdiction. It has been there held, based on state constitutional grounds, that a judicial hearing is necessary. *Rogers v. Commissioner*, 390 Mass. 489, 458 N.E.2d 308 (Mass. 1983); *In Re Richard Roe III*, 421 N.E.2d 40 (Mass. 1981). In a study of the impact of the *Rogers* decision the authors found that less than 1% of the petitions seeking an order for overriding the patient's refusal of medication were denied. Massachusetts Department of Mental Health, Draft Report: The Impact of *Rogers v. Commissioner* on the Department of Mental Health 22 (1988) [hereinafter *Massachusetts Report*]. Other studies have shown that 4% to 5% of treatment refusals are upheld by the courts, which is comparable to the rate seen when there is a non-judicial professional review mechanism. Appelbaum & Hoge, *The Right to Refuse Treatment: What the Research Reveals*, 4 Behav. Sci. & Law 279, 282 (1986); Bloom, et. al., *An Empirical View of Patients Exercising Their Right to Refuse Treatment*, 7 Intern'l J. Law & Psychiatry 315; Hoge, Gutheil & Kaplan, *The Right to Refuse Treatment under Rogers v. Commissioner: Preliminary Empirical Findings and Comparisons*, 15 Bull AAPL 163, 167 (1987).

As this Court noted in *Parham v. J.R.*, *supra*, at 609:

[W]e do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative

hearing officer after a judicial-type hearing. Even after a hearing, the nonspecialist decisionmaker must make a medical-psychiatric decision.

There is nothing to indicate that the risk of error is significantly reduced by a formal judicial type hearing. *Id.* at 613. Indeed, "when judges are forced to act as physicians, they, too, tend to think the way physicians do." Appelbaum, *The Right to Refuse Treatment with Antipsychotic Medications: Retrospect and Prospect*, 145 Am. J. Psychiatry 413, 417.

Apart from the apparent fact that judicial hearings do not produce results different from those obtained in other contexts, there is the further fact that such hearings can heighten conflict between the patient and the medical staff, and they can exacerbate the conflict already existing between patients and their families if family members are forced to testify in hearings against their relatives. See *Parham v. J.R.*, *supra*, at 610.

C. The Government Has A Substantial Interest in Not Incurring the Costs and Administrative Burdens Required by Judicial Hearings

There are substantial costs, both financial and administrative, incurred as a result of judicial treatment refusal hearings. Such hearings divert psychiatric personnel from short-staffed hospitals to attend court hearings, disrupt the relationship between the treatment team and the patient, result in delays in initiating treatment, and create risks of harm to the patient, other patients, and hospital staff during the treatment delay. Wettstein, *Involuntary Administration of Psychotropic Drugs: The Case Against Requiring Prior Court Review*, 6 Hospital Law Newsletter 3 (1989).

Judicial hearings require a huge investment of time by the treatment staff. As the Court pointed out in *Parham v. J.R.*, *supra*, at 613:

One consequence of increasing the procedures the state must provide . . . will be that mental health professionals will be diverted even more from the treatment of patients in order to travel to and participate in and wait for what could be hundreds or even thousands of hearings each year. Obviously, the cost of these procedures would come from the public monies the legislature intended for mental health care.

A Massachusetts study of patients in state facilities revealed that 4,800 additional hours of clinical staff time during an 18-month period were spent in preparing for and appearing at the hearings required in that state. See *Massachusetts Report*, *supra*, at 23. Another study documented psychiatrists spending 10.2 hours on each of these cases. Veliz & James, *supra*, at 64. Not included was the additional staff time required to deal with the behavior of patients who had refused medication.

In a case whose facts almost directly parallel those in the case now before this Court, an *en banc* Fourth Circuit Court of Appeals stated:

It has to be recalled that the government's role here is not that of punitive custodian of a fully competent inmate, but benign custodian of one legally committed to it for medical care and treatment—specifically for psychiatric treatment. In this relationship the government is under a specific statutory duty to attempt to restore mental competency so that the patient may be returned to a free society. In these circumstances, the imposition of extensive administrative burdens upon the government's efforts to discharge this affirmative obligation must be weighed with great care in the due process balance.

United States v. Charters, 863 F.2d 302, 312 (4th Cir. 1988).

There are also the costs to the individual and the staff resulting from the lengthy delays which invariably seem to be part of the legal system. In one study "the waiting period between filing the petition and the actual court hearing date was ... [found to be,] on the average, 4.5 months (range 2-7 months)." Veliz & James, *supra*, at 63. The experience thus far in Washington

State has varied, with delays of two weeks or more being common. These delays and the attendant tremendous burdens placed on the staff have resulted in numerous private hospitals, which had in the past frequently provided care to civilly committed mentally ill people, choosing not to take these patients anymore. In Washington State this has resulted in individuals and their families having to travel many hours to the state hospital, rather than being able to avail themselves of the hospitals within their community.

The delays caused by waiting for judicial hearings necessarily result in lengthened hospitalizations and these particularly can strain mental health budgets. If the usual duration of hospitalization is two weeks, but the patient who refuses treatment now will have a two-month waiting period before treatment can begin and become effective, then the costs for his care are increased by 400%, not counting the cost of the legal procedure itself. Someone winds up having to pay. In the public system these costs have to be absorbed by the taxpayers. In the private setting the costs are usually absorbed by private insurers or taken as losses by the treating hospitals, and then passed on to the public in terms of increased costs of care.

In addition to the well documented strains on the mental health system, and the negative impact for the patient resulting from delayed treatment, heavy burdens are placed on the legal system. Each case requires three attorneys—a prosecutor, a defense attorney, and a guardian ad litem. In Massachusetts the courts, “at a rate of 126 times per month . . . have been asked by the Department [of Mental Health] to consider” whether a patient has a right to refuse treatment. *Massachusetts Report, supra*, at 1. This does not include requests by private treatment facilities. As of June, 1988, the Department of Mental Health in Massachusetts had over 2,000 active cases requiring ongoing court review. For the Department this involved 3,000 hours of paralegal time, and each case involved at least five hours of time by a Department attorney. *Massachusetts Report, supra*, at 24, 28.

In 1988 there were 7,560 involuntary detentions of adults in Washington. All were hospitalized against their will. If only 20% of these individuals refused medication, this would require

1,512 ‘treatment’ hearings. Because of the large geographical size of the state of Washington, the burden would be far greater than that already demonstrated in Massachusetts. In contrast, if there were an independent medical review, costs and time delays would be greatly reduced. In Oregon, for example, it is estimated that the additional costs are approximately only \$100.00 for each outside psychiatric consultation. Godard, et. al., *The Right to Refuse Treatment in Oregon: A Two Year Statewide Experience*, 4 Behav. Sci. & Law 293, 303 (1986). In cases which require immediate attention, review could occur within a day. For individuals confined for long term care, reviews could be undertaken on a periodic basis, as occurred in *Harper* with regard to prison inmates.

When the *Mathews* balancing test is employed, it becomes obvious that the individual’s due process interests can be protected by an informal medical decisionmaking process, such as a second opinion from an uninvolved psychiatrist. This avoids the substantial administrative burdens and costs which occur when a judicial hearing is required.

IV. CONCLUSION

Recognizing that a civilly committed mentally ill person has a right to refuse medication, but that that right is counterbalanced with his right to treatment most conducive to enhancing restoration of his liberty, as well as with the state's interest in avoiding substantial financial and administrative burden, the amici respectfully request that the decision of the Washington Supreme Court be reversed. We urge that the Court's holdings in *Parham v. J.R.*, *supra*, and *Youngberg v. Romeo*, *supra*, be extended, so that when an involuntarily committed mentally ill person refuses antipsychotic medication, review by an independent medical decisionmaker, relying on his professional judgment, shall be deemed to properly protect the due process interests of the patient.

Respectfully submitted,

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AMICUS CURIAE

BRIEF

9
NO. 88-599

In The

SUPREME COURT OF THE UNITED STATES

October Term, 1988

STATE OF WASHINGTON, et al.,
Petitioners,

v.

WALTER HARPER
Respondent.

**BRIEF OF THE STATE OF CALIFORNIA
AMICUS CURIAE IN SUPPORT OF PETITIONERS**

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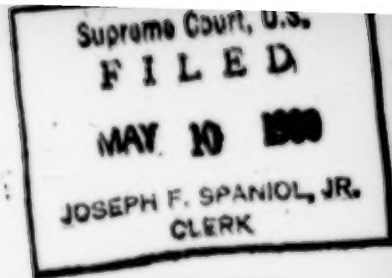


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**BRIEF OF THE STATE OF CALIFORNIA
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INTEREST OF THE STATE OF CALIFORNIA

The issues presented by petitioner concern the rights of state prisoners and, by necessary implication, of persons in state custody under civil process, to refuse

antipsychotic medication, as well as the affirmative obligation of their custodians to afford efficacious medical treatment for a diagnosed serious mental illness. The opinion of the Supreme Court of Washington holds that prisoners have an absolute right to refuse medically prescribed antipsychotic drug treatment unless: (1) there has been judicial determination that the state has a compelling interest in administering medication; and (2) that the particular prescribed medication is both necessary and effective for furthering that interest. The Court below further held that an order for involuntary medication can set such time limits and conditions on the administration of the medication as the trial court deems appropriate under the circumstances.

The State of California's Department of Corrections is responsible for providing psychiatric treatment for many of its 78,000 prisoners in need of such treatment. The California Department of Mental Health is similarly responsible for the care and treatment of approximately 4,600 patients in five state hospitals. A decision by this Court which requires judges to prescribe the modality of psychiatric treatment will have a significant adverse impact on the operation of both departments as well as on the local mental health facilities in California which provide care and treatment to approximately 125,000 patients each year.

California law already provides procedural protections well in excess of the minimum procedures necessary to protect the limited right of a civilly or criminally committed person to refuse antipsychotic

medication. Under California statutory law (Cal. Welf. & Inst. Code §§ 5350, 5357, 5358.2) both civilly and criminally committed persons have a "right to refuse involuntary psychotropic medication absent a judicial determination of their incompetency to do so." Keyhea v. Rushen, 178 Cal.App.3d 526, 536, 542; 223 Cal.Rptr. 746, 751, 755 (1986). California law requires only that a court determine that the person receiving involuntary antipsychotic medication is, as a result of mental illness, gravely disabled or dangerous and incompetent to give (or to withhold) informed consent. Id. at 536.^{1/} Once that determination is made the court intrudes no further in the medical process.^{2/} Indeed, the California courts have specifically held in the area of electro-convulsive

1. "Grave disability" is defined as a "condition in which a person, as a result of a mental disorder, is unable to provide for his basic personal needs for food, clothing, or shelter...." Cal. Welf. & Inst. Code § 500b, subd. (h)(1). A mentally ill person is a danger to others if, on the basis of certain specified behavior he presents "a demonstrated danger of inflicting substantial physical harm upon others." Cal. Welf. & Inst. Code § 5300, subds. (a), (b), (c).)

2. A recent opinion of the California Court of Appeal holds, however, that the state can involuntarily medicate a competent dangerously mentally ill prisoner upon a judicial finding that there is no less restrictive alternative to antipsychotic medication which satisfies the institution's security needs. In re Woodall, A041054, Dist. One, Div. Four, filed April 18, 1988. This opinion, which has not yet appeared in the official reporter, is attached as Appendix A.

treatment that while a judicial determination of incompetency is required to provide involuntary treatment, courts should not decide medical questions such as whether the treatment is definitely needed or is the least restrictive alternative. Conservatorship of Fadley, 159 Cal.App.3d 440, 446; 205 Cal.Rptr. 572, 575 (1984).

The decision of the Washington Supreme Court would interject trial courts into precisely the sort of medical decision making which the California courts have rejected. The Washington state court below has construed the Constitution of the United States effectively also to require that a judge prescribe the modality and duration of medical treatment for mental illness. We believe that this intrusion, which would carry the court beyond its expertise, is excessive and potentially dangerous.

Moreover, a decision by this Court that judicial hearings are necessary before prisoners may be involuntarily administered particular antipsychotic medication, especially the intrusive procedures required by the Washington Supreme Court, would preclude the California Legislature from amending state law to eliminate the statutory requirement for prior judicial hearings. This is of particular importance because the issue of what procedures, if any, are required under California's present state statutory law to provide involuntary antipsychotic medication is pending before the Supreme Court of California in Riese v. St. Mary's Hospital and Medical Center, 196 Cal.App.3d 1388, 243 Cal.Rptr. 241 (1987) rev. granted March 3, 1988

(S004002). Changes in California's statutory scheme may be proposed after the decision in this case.

SUMMARY OF ARGUMENT

Since this Court's opinion in Youngberg v. Romeo, 457 U.S. 307, 102 S.Ct. 2452, 73 L.Ed.2d 28 (1982), the lower federal courts have been virtually unanimous in holding that the decision to administer involuntary antipsychotic medication, while implicating a liberty interest, does not violate the constitutional rights of the patient if the doctor prescribing the medication did so in the exercise of professional judgment. Judicial hearings are not, under these authorities, necessary to authorize such involuntary treatment.

Use of the professional judgment standard narrows the scope of judicial review. Under that standard courts must defer to the professional judgment of the psychiatrist. Whether the decision was medically correct or the most appropriate choice is not at issue. The only issue is whether the decision was made by an appropriate medical professional in the exercise of professional judgment, i.e., not arbitrarily.

Application of the professional judgment standard does not denigrate the interest of the person who is refusing medication and is consistent both with the deliberate indifference standard under the Eighth Amendment, and with relegation of medical malpractice

questions to the field of tort law.^{2/} See, Estelle v. Gamble, 429 U.S. 97, 104, 107, 97 S.Ct. 285, 291, 292, 50 L.Ed.2d 251. Adoption of the professional judgment standard simply acknowledges that the residual risk of an erroneous medical decision is not so substantial as to require additional procedural safeguards and that after an exercise of such professional judgment, the patient's interest in defeating the government's obligation efficaciously to treat mentally ill persons does not justify the burden and expense that additional procedures would entail.

The decision of the court below, however, plunges the judiciary into the business of pre-approving medical diagnosis and treatment. Contrary to prior admonitions by this Court, it moves from a premise regarding the fallibility of the psychiatric profession to the unwarranted conclusion that the solution to that fallibility is to move the medical decisionmaking power from trained psychiatrists to untrained judges.

Assuming *arguendo* that some additional procedures are required to protect the interest of a prisoner in refusing medication, the most that should be required is internal administrative review of the decision to administer antipsychotic medication involuntarily.

3. On the other hand, judicial determinations of modality of treatment may effectively bar subsequent resort to malpractice actions because the Court order pursuant to which the treatment was afforded would be an available and perhaps absolute defense.

ARGUMENT

THERE IS NO CONSTITUTIONAL RIGHT TO A JUDICIAL HEARING BEFORE A MENTALLY ILL PATIENT MAY INVOLUNTARILY BE ADMINISTERED ANTIPSYCHOTIC MEDICATION AS PRESCRIBED BY A PHYSICIAN IN EXERCISE OF PROFESSIONAL JUDGMENT.

A. Introduction

The Washington Supreme Court in this case held that to administer antipsychotic medication to a nonconsenting prisoner, a court must find that the state has proved "(1) a compelling state interest to administer antipsychotic drugs, and (2) the administration of the drugs is necessary and effective for furthering that interest." (footnote omitted) Harper v. Washington, 110 Wash.2d 873, 882-883; 759 P.2d 358, 364. The panoply of procedural rights created by the court includes the right to be present at the judicial hearing; to be represented by counsel; to present evidence; to cross-examine witnesses; to be proceeded against under the rules of evidence; to remain silent and to view and copy all petitions and reports in the court file. Id. at 884, 759 P.2d at 365. Finally, "if the court grants the order for involuntary medication, it may place such time limits and conditions on the administration of the medication as are appropriate under the circumstances of the case." Id., at 884, 759 P.2d at 365, quoting In re Schuoler, 106 Wash.2d

500, 511, 723 P.2d 1103 (1986).^{4/}

These standards and procedures exceed those required under the Constitution to protect the limited interest of prisoners. The holding of the court below seems to be based on a lack of confidence in the psychiatric profession. Thus this Court's decision in Vitek v. Jones, 445 U.S. 480, 495, 100 S.Ct. 1254, 1265, 63 L.Ed.2d 552, is quoted below for the proposition that "[i]t is precisely 'the subtleties and nuances of psychiatric diagnosis' that justifies the requirement of adversary hearings." 110 Wash.2d at 881, 759 P.2d at 363. But this language should be tempered by the result in Vitek, which required only review by an "independent decisionmaker," not a judicial trial, to transfer a prisoner to a mental hospital. Vitek, 480 U.S. at 495-496, 100 S.Ct. at 1265. Moreover, the state court below entirely overlooked this Court's opinion in Parham v. J.R., 442 U.S. 584, 99 S.Ct. 2493, 61 L.Ed.2d 101 (1979) which acknowledged the "fallibility of medical and psychiatric diagnosis," yet held that these shortcomings did not justify, on due process grounds, shifting medical decisions from medical specialists to judges or administrative hearing officers. Id., at 609.

4. These standards and procedures are taken by the court below from Washington's process for involuntary medication of competent persons in custody under state civil process. Harper was not found incompetent. For incompetent patients, an additional complex calculus also would be imposed under the decision in In re Ingram, 102 Wash.2d 827, 838-42, 689 P.2d 1363 (1984). Harper v. Washington, 110 Wash.2d at 883, 759 P.2d at 365.

Thus to the extent that the lower court's opinion is based on its perception of the failings of the psychiatric profession, its conclusion that the Constitution requires that those failings be remedied by interposing judges as medical decisionmakers has already been considered and rejected by this Court.

B. Prisoners Have a Liberty Interest in Refusing Antipsychotic Medication.

Procedural due process is a flexible concept and "calls for such procedural protections as the particular situation demands." Morrissey v. Brewer, 408 U.S. 471, 481, 92 S.Ct. 2593, 2600, 33 L.Ed.2d 484 (1972). The process due in particular situations generally requires consideration of three distinct factors:

First, the private interest that will be affected by the official action; second the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements would entail.

Matthews v. Eldridge, 424 U.S. 319, 335, 96 S.Ct. 893, 903, 47 L.Ed.2d 18 (1976).

This Court, in Youngberg v. Romeo, 457 U.S. 307, 102 S.Ct. 2452, 73 L.Ed.2d 28, considered whether a person involuntarily committed to a state institution as mentally retarded has substantive rights under the Due Process Clause of the Fourteenth Amendment regarding certain conditions of his confinement. The Court concluded that an involuntarily committed mentally retarded person retains liberty interests in safety and freedom from bodily restraint. Id. at 319-20, 102 S.Ct. at 2459-60. Following Youngberg several circuit courts of appeals concluded that persons involuntarily committed for mental health treatment retain a liberty interest in refusing unwanted antipsychotic medication. United States v. Charters, 863 F.2d 302, 305 (4th Cir. 1988) (en banc); Project Release v. Prevost, 722 F.2d 960, 977-79 (2d Cir. 1983); Rennie v. Klein, 720 F.2d 266, 268-69 (3rd Cir. 1983) (en banc).

In light of Youngberg, Charters, Project Release, and Rennie, and because Washington does not contend otherwise, amicus does not here contest that the decision to administer involuntary antipsychotic medication to a person in state custody implicates a liberty interest under the Fourteenth Amendment. That due process is thereby deemed applicable, however, does not end the inquiry. The question remains, what process is due?

C. Protection of a Prisoner's Liberty Interest in Refusing Antipsychotic Medication Requires Only That the Decision to Administer the Medication Be Made by a Qualified Medical Professional in the Exercise of Professional Judgment.

As this Court has stated, the question of whether a person has a constitutional right to refuse treatment with antipsychotic medication has both substantive and procedural aspects:

"[t]he substantive issue involves a definition of that protected constitutional interest, as well as identification of the conditions under which competing state interests might outweigh it. The procedural issue concerns the minimum procedures required by the Constitution for determining that the individual's liberty interest actually is outweighed in a particular instance."

Mills v. Rogers, 457 U.S. 291, 299, 102 S.Ct. 2442, 2448, 73 L.Ed.2d 16 (1982).

Amicus submits that the substantive and the procedural due process analysis each yield the same result.

To determine what process is due "it is necessary to balance 'the liberty of the individual' and 'the demands of an organized society.'" Youngberg, 457 U.S. at 320, 102 S.Ct. at 2460, citing Poe v. Ullman, 367 U.S. 497, 542,

81 S.Ct. 1752, 1776, 6 L.Ed.2d 989 (1961) (Harlan, J., dissenting). After balancing these interests in the care and treatment received by mentally retarded patients, this Court in Youngberg held:

"the Constitution only requires that the courts make certain that professional judgment in fact was exercised. It is not appropriate for the courts to specify which of several professionally acceptable choices should have been made."

Id., 457 U.S. at 321, 102 S.Ct. at 2461 (quoting Romeo v. Youngberg, 644 F.2d 147, 178 (3rd Cir. 1980) (Seitz, C.J., concurring)).

"[t]he courts must show deference to the judgment exercised by a qualified professional.... [I]nterference by the federal judiciary with the internal operations of these institutions should be minimized. Moreover, there certainly is no reason to think judges are more qualified than appropriate professionals in making such decisions."

457 U.S. at 322-323, 102 S.Ct. at 2461-62.

Since Youngberg, a substantive due process case, this nation's courts of appeals have been virtually unanimous in following the "professional judgment"

standard.^{2/} In so doing they have generally accepted the exercise of professional judgment as a procedural standard^{6/} and have rejected the ideas that prior judicial authorization is necessary to administer antipsychotic medication involuntarily and that the decision to administer such medication requires a compelling state interest and consideration of alternative means of treatment. The constitutional interpretation by the Washington Supreme Court conflicts with these federal authorities. See United States v. Charters, 863 F.2d at 312; Dautremont v. Broadlawns Hosp., 827 F.2d 291, 300 (8th Cir. (1987)); Project Release v. Prevost, 722 F.2d at 980-981; Rennie V. Klein, 720 F.2d at 269.

In Rennie v. Klein, the Court of Appeals for the Third Circuit held that the evaluation of a mentally ill patient by a doctor to determine whether the patient may be administered antipsychotic drugs must be the product of the medical authorities' professional judgment. That judgment and the resulting decision to administer medication "is presumed valid unless it is shown to be a

5. The one possible exception is the Court of Appeals for the Tenth Circuit which appeared to adopt a hybrid of the "professional judgment" standard and a less restrictive alternative test. See Bee v. Greaves, 744 F.2d 1387, 1395-96 (10th Cir. 1984).

6. But see Project Release v. Prevost, 722 F.2d at 981 which holds that procedural due process requires an opportunity for hearing and review of a decision to administer antipsychotic medication, but such a hearing need not be judicial in nature.

substantial departure from accepted professional judgment practice or standards." Rennie, 720 F.2d at 269, citing Youngberg, 457 U.S. at 323.

As a matter of substantive due process, it is important to consider exactly what is and is not required under the professional judgment standard. Acceptance of the professional judgment standard does not permit well-meaning but misguided physicians simply to inject by force every patient whom he or she believes to be mentally ill.

As Chief Judge Seitz stated in Rennie:

The decision whether to administer drugs is by its nature fact-specific. As a general matter, however, the physician must consider both the welfare of the patient and the interests of society as a whole. This requires a consideration of whether there may be any harmful effects to the patients and whether there are possible alternatives to the use of the drugs. In addition, the physician's decision to use the drugs must be based on a contemporary judgment that the drugs either (1) are an appropriate part of the effort to treat the existing disorder that warrants the patient's continued confinement, or (2) must be administered in response to, or in anticipation of, the patient's violent outbreaks. Use of the drugs may not be justified purely on economic or administrative grounds, as part of an attempt

to "warehouse" the patient."

(Rennie v. Klein, 720 F.2d at 274 (Seitz, C.J. (conc.))).

Lack of capacity to consent may also be a factor for the physician to consider - albeit not a controlling or necessarily determinative factor. The doctor might consider not only the need for medication but also the fact that it is being prescribed against the patient's wishes. If, as often suggested, a physician's negotiations with an unconsenting patient may itself have some therapeutic value, the doctor's attempt to work with his patient to form a "therapeutic alliance" might also be considered as the doctor exercises professional judgment in prescribing involuntary medication.

The medical relevance, materiality, and weight of particular facts which might bear upon whether to prescribe psychotropic medication ought to depend on professional medical judgment, unencumbered by constitutionalized guidelines which the courts may attempt to fashion with some precision. While the fact specific nature of the decision to administer antipsychotic medication makes it imprudent to fashion precise constitutional guidelines, this does not render the professional judgment standard vague nor does it denigrate the interest of the person to be medicated. As a matter of substantive due process, the professional judgment standard works very much like the standard articulated by this Court under the Eighth Amendment for dealing with prisoner claims of inadequate medical care.

In Estelle v. Gamble, 429 U.S. at 104, 97 S.Ct. at 291, this Court held that "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' [citation omitted] proscribed by the Eighth Amendment." Negligence in diagnosing or treating a medical condition, however, "does not become a constitutional violation merely because the victim is a prisoner." Id. at 106, 97 S.Ct. at 292. Deliberate indifference to serious medical needs may be evidenced by the failure of prison officials to provide a system of ready access to adequate and competent medical care, or adequate procedures for responding to emergencies. See e.g., Hoptowit v. Ray, 682 F.2d 1237, 1253 (9th Cir. 1982). A prisoner, however, has no right to a particular course of treatment, only to one which is within the realm of reasonable medical judgment. Bowring v. Godwin, 551 F.2d 44, 48 (4th Cir. 1977). Thus, issues such as whether a particular course of treatment was the most appropriate, or whether a particular diagnostic technique should have been undertaken, are relegated to state tort law. E.g. Estelle v. Gamble, 429 U.S. at 107, 97 S.Ct. at 293 (whether an x-ray of plaintiff was medically indicated is question for state courts under their tort law).

Similarly, under the professional judgment standard, issues regarding whether antipsychotic medication is the most appropriate treatment, and other issues regarding modality of treatment are properly relegated to state law. In requiring that prison officials not act with deliberate indifference to a prisoner's serious medical needs, the Eighth Amendment is satisfied by an actual exercise of professional medical judgment. Similarly, substantive due

process should be satisfied where a psychiatrist has exercised professional medical judgment in prescribing antipsychotic medication.

Thus, by adopting the professional judgment standard in cases in which a psychiatrist decides to prescribe involuntary antipsychotic medication this Court would be putting the constitutional liberty interest in refusing a course of medical treatment on an equal footing with the Eighth Amendment interest in avoiding cruel and unusual punishment. This is entirely appropriate. To hold otherwise would subject the decision of whether treatment is necessary in the first place to one level of scrutiny, see, Bowring v. Godwin, 551 F.2d at 47-48, then elevate the standard if the decision is to treat the prisoner without his consent. In either case, however, the decision from the doctor's perspective is the same -- an exercise of professional judgment to determine the most appropriate course of medical treatment. Amicus submits that to hold that the due process clause provides the same level of protection as the Eighth Amendment fully protects the rights of inmates while providing a workable standard for the professionals charged with their care.

As a matter of procedural due process, the Fourth Circuit in United States v. Charters, 863 F.2d at 314, stated that the use of the professional judgment standard in cases of involuntary antipsychotic medication is no different from other areas in which courts act as reviewers of professional decisions such as cases of prison transfers and disciplinary sanctions. As this Court has held in the

prison context, the fact that a liberty interest exists does not mean that it must be protected by elaborate procedural rights, such as those imposed by the Washington Supreme Court, which are akin to those in a criminal trial. E.g., Wolff v. McDonnell, 418 U.S. 539, 560, 94 S.Ct. 2963, 2977, 41 L.Ed.2d 935 (1974). Instead, in reviewing decisions of prison administrators in areas such as adjudication of prison disciplinary charges and assignment of prisoners to segregated housing, courts must defer to the expertise of prison administrators. E.g., Superintendent v. Hill, 472 U.S. 445, 455-456, 105 S.Ct. 2768, 2773-2774, 86 L.Ed.2d 356 (1985); Hewitt v. Helms, 459 U.S. 460, 474, 103 S.Ct. 864, 872-73, 74 L.Ed.2d 675 (1983). Similar deference by the courts is appropriate in the case of the medical determination of whether to administer antipsychotic medication to a mentally ill prisoner, even on an involuntary basis. Indeed, it may be fair to say that the courts are less well equipped to second guess professional medical judgments than they are to second guess professional correctional decisions. In reviewing such a medical decision, courts should defer to the professional judgment of the psychiatrist responsible for making the medical decision.²⁷ United States v.

7. Admittedly in reviewing the decision to discipline or segregate a prisoner a court is reviewing the exercise of discretion by a prison hearing officer or committee. Amicus contends that no such hearing is required in cases involving the decision to administer antipsychotic medication. In Part E, infra, we suggest that if any procedures beyond the first exercise of professional judgment are required, the Constitution requires no more

Charters, 863 F.2d at 312-14.

D. A Requirement of Judicial Hearings Prior to the Involuntary Administration of Antipsychotic Medication is Unduly Burdensome, Unnecessary, Wasteful of Psychiatric Resources, and Imprudent.

Perhaps the most pointed discussion of the problems inherent in a judicial review scheme such as the one imposed by the Washington Supreme Court is the Fourth Circuit's recent en banc opinion in Charters:

Several critical features of such a [prior judicial determination] regime in addition to its obvious complexity draw its potential for added protective value in serious question. First off, it skews the normal due process

than some administrative review such as obtaining a second medical opinion from a psychiatrist who is not a treating physician in the particular case, nor subordinate to the treating physician. Use of the professional judgment standard coupled with such an administrative review would closely parallel the accepted review of the decision making in prison disciplinary and segregation cases where the reviewing court neither notices the decision in the first instance nor reviews the decision de novo.

regimes under which the courts act simply as guarantors of due process by various sorts of officials in various kinds of non-judicial proceedings. The proposed regime would install the ... courts as the base-line providers of procedural due process, collapsing their normal review function into this threshold function. With this would go all the cumbersomeness, expense, and delay incident to judicial proceedings every time an involuntary medication decision had to be made for any inmate. In such a regime, the role of the institutional medical personnel charged with the care and treatment of inmates would simply be that of expert witnesses defending their opinions in judicial proceedings rather than that of base-line decision makers. Presumably, their opinions, both on "competence" and on "best interests," would be entitled to no greater deference than the conflicting opinions of the outside expert witnesses whose testimony surely can be anticipated. [footnote omitted]. District judges would thereby be cast in the role of making the primary decisions on purely medical and psychiatric questions, rather than reviewers of such decisions made by qualified professionals.

United States v. Charters, 863 F.2d. at 309.

The practical problems of protracted proceedings

were discussed by this Court in Parham v. J.R. 442 U.S. 584, 99 S.Ct. 2493, L.Ed.2d 101. The Court noted that the state has a genuine interest in allocating priority to the diagnosis and treatment of patients rather than to "time consuming procedural minuets. . . ." Id., at 605, 99 S.Ct. at 2506. Moreover, a factor that must be considered in determining necessary procedures

"is the utilization of the time of psychiatrists, psychologists and other behavioral specialists in preparing for and participating in hearings rather than performing tasks for which their special training has fitted them. Behavioral experts in courtrooms and hearings are of little help to patients" Id., at p. 606, 99 S.Ct. at 2506.^{8/}

In Parham this Court held that the "risk of error

8. The Parham Court in a footnote [(Parham v. J. R., 442 U.S. at 605-606, fn. 14, 99 S.Ct. at 2506)] approvingly cited a law review article by Judge Friendly, (Friendly, "Some Kind of Hearing," 123 U.Pa. L. Rev. 1267, 1276 (1975) wherein he stated:

"It should be realized that procedural requirements entail the expenditure of limited resources, that at some point the benefit to individuals from an additional safeguard is substantially outweighed by the cost of providing such protection, and that the expense of protecting those likely to be found undeserving will probably come out of the pockets of the deserving."

inherent in the parental decision to have a child institutionalized for mental health care is sufficiently great that some kind of inquiry should be made by a 'neutral factfinder' to determine whether the statutory requirements for admission are satisfied" *Id.*, at p. 606, 99 S.Ct. 2506. The Court then went on to state that a staff psychiatrist was sufficient to act as the neutral factfinder because

"[d]ue process has never been thought to require that the neutral and detached trier of fact be law trained or a judicial or administrative officer. . . .

Although we acknowledge the fallibility of medical and psychiatric diagnosis (see *O'Connor v. Donaldson* 422 U.S. 563, 584, 95 S.Ct. 2486, 2498, 45 L.Ed.2d 396 (1975) (Burger, C.J. concurring)) we do not accept the notion that the shortcomings of specialists can always be avoided by shifting the decisions from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing. Even after a hearing, the nonspecialist decisionmaker must make a medical-psychiatric decision. Common human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the

commitment and treatment of mental and emotional illness may well be more illusory than real." *Id.*, at pp. 607-609, 99 S.Ct. at 2506, 2507-2508.

The policy in favor of the professional judgment standard and against the imposition of the sort of "procedural minuets" required by the Washington court cannot be better stated than it was in *Parham*. Amicus collectively is responsible for the care and treatment of tens of thousands of mentally ill persons each year -- both prisoners and civilians. Antipsychotic medications are the treatment of choice for many mentally ill persons in local mental health centers, state mental hospitals and in many prisons and jails. The incredible social cost described in *Parham* will be felt in virtually every county in this state and at every level of mental health care. Mentally ill persons need more time for care and treatment by their physicians, not less time while their doctors prepare for adversarial sparring in court hearings.

E. Assuming Arguendo that a Hearing Is Necessary to Administer Medication Involuntarily, the Constitution Does Not Require More Than an Administrative Review.

In *Vitek v. Jones*, 445 U.S. at 494, 100 S.Ct. at 1264, this Court held that the transfer of a prisoner to a mental hospital constituted the deprivation of a liberty interest which was protected by the due process clause.

The Court recognized the possible stigmatizing effect of confinement in a mental hospital and compelled treatment in the form of mandatory behavior modification programs as factors which give rise to the need for some additional procedural protections. *Id.* at 492, 100 S.Ct. at 1263. The Court recognized the following procedures as sufficient to protect the prisoner's interest:

- A. Written notice to the prisoner that a transfer to a mental hospital is being considered;
- B. A hearing, sufficiently after the notice to permit the prisoner to prepare, at which disclosure to the prisoner is made of the evidence being relied upon for the transfer and at which an opportunity to be heard in person and to present documentary evidence is given;
- C. An opportunity at the hearing to present testimony of witnesses by the defense and to confront and cross-examine witnesses called by the state, except upon a finding, not arbitrarily made, of good cause for not permitting such presentation, confrontation, or cross-examination;
- D. An independent decisionmaker;
- E. A written statement by the factfinder as to the evidence relied on and the reasons

for transferring the inmate;

F. Availability of legal counsel, furnished by the state, if the inmate is financially unable to furnish his own;^{9/} and

G. Effective and timely notice of all the foregoing rights.

Id. at 494-95, 100 S.Ct. at 1264-65.

Assuming arguendo that a hearing of some sort is necessary in cases in which prison psychiatrists wish to administer antipsychotic medications to an unwilling prisoner, nothing more than the internal administrative review required under *Vitek* is necessary.

9. Only a plurality of the Court agreed that counsel is required. In his concurring opinion Justice Powell concluded that the Constitution does not compel the appointment of a licensed attorney to represent the inmate in his administrative transfer hearing. "Due process will be satisfied so long as an inmate facing involuntary transfer to a mental hospital is provided qualified and independent assistance." *Vitek*, 445 U.S. at 500, 100 S.Ct. at 1267 (Powell, J. concurring). The Fourth Circuit subsequently adopted the requirement that the inmate need only be provided with "qualified and independent assistance", not necessarily from an attorney, to help a prisoner prepare his objections to a transfer to a prison mental hospital. *Baugh v. Woodard*, 808 F.2d 333, 335 (4th Cir. 1987).

The state court below rejected the contention that Vitek's procedures were adequate in cases involving involuntary antipsychotic medication. Harper, 110 Wash.2d at 880-881, 759 P.2d at 363. The state court's rejection of Vitek is incorrect for two reasons. First, the state court apparently believed that in Vitek this Court was concerned only with "stigmatizing consequences" of transfer to a mental hospital whereas the present case involved the administration of mind altering drugs with adverse, possibly permanent, side effects. Id. at 880, 759 P.2d at 363. This assumes, however, that the Vitek Court was unaware that prisoners transferred to a mental hospital would receive treatment there. It would make no sense to approve a set of procedures for the involuntary transfer of a prisoner to a mental hospital yet hold that the hospital could not then involuntarily treat the prisoner absent further proceedings.

Second, assuming that the issue of involuntary treatment is not subsumed within Vitek's analysis of involuntary transfer, the state court's holding ignores this Court's reasoning in Parham. Even if the patient's interest in avoiding a transfer to a mental hospital is different from the interest in refusing antipsychotic medication, each decision is a medical one. The state court below provides no basis for its conclusion that one medical decision -- involuntary transfer -- may be made by an independent medical decisionmaker while another medical decision -- involuntary medication -- must be made by a judge. As previously noted, in Parham this Court rejected the idea that the fallibility of psychiatric diagnosis can be remedied by shifting the decisionmaking

power from trained psychiatrists to judges. Parham v. J.R., 442 U.S. at 609, 99 S.Ct. at 2507-08. A medical "neutral factfinder" is sufficient to review a parent's decision to have a child institutionalized for mental health treatment, id. at 606, 99 S.Ct. at 2506, and a medical "independent decisionmaker" is sufficient to transfer a prisoner to a mental hospital. Vitek v. Jones, 445 U.S. at 494-95, 100 S.Ct. at 1264-65. The Constitution simply does not require more to treat than it does to institutionalize in the first place.

Assuming arguendo that administrative review is required, it should be required only in cases in which the state chooses to medicate involuntarily sentenced prisoners who have not had a prior judicial determination of their need for mental health treatment. No further review should be required in cases in which a person has been judicially committed for the purpose of receiving mental health treatment. But see, Project Release v. Prevost, 722 F.2d at 981 (holding that "due process requires an opportunity for hearing and review of a decision to administer antipsychotic medication - but such a hearing need not be judicial in nature.")

This Court's holding in Vitek requiring administrative review of the decision to transfer a prisoner to a mental hospital was based on its finding that "involuntary commitment to a mental hospital is not within the range of conditions of confinement to which a prison sentence subjects an individual." Vitek, 445 U.S. at 493, 100 S.Ct. at 1264. The Court noted that none of its decisions "holds that conviction of a crime entitles a State

not only to confine the convicted person but also to determine that he has a mental illness and to subject him involuntarily to institutional care in a mental hospital." Id., 100 S.Ct. at 1264. In contrast, treatment of mental illness is one of the generally recognized justifications for confinement of a person in a mental health facility. E.g., O'Connor v. Donaldson, 422 U.S. at 573-74, 95 S.Ct. 2492-93; Jackson v. Indiana, 406 U.S. 715, 736-37, 92 S.Ct. 1845, 32 L.Ed.2d 435, 1857-58 (1972); Humphrey v. Cady, 405 U.S. 504, 509; 92 S.Ct. 1048, 1052, 31 L.Ed.2d 394 (1972). Thus, unlike the person sentenced to state prison, for a person who has been judicially committed to a mental hospital -- either as a civil commitment, as not guilty by reason of insanity or incompetent to stand trial in a criminal case or on any other basis -- mental health treatment is obviously within the range of conditions to which his commitment subjects him. Amicus is aware of no form of involuntary commitment to a mental hospital to which a non-prisoner can be subjected without a judicial hearing. During that hearing a determination is made of the person's mental condition. Such a judicial hearing upon commitment obviates the need for any further administrative review. Thus, assuming arguendo that Vitek requires an administrative hearing in cases in which the state wishes to treat a prisoner against his will with antipsychotic medication, that requirement should not be extended to persons who have already been judicially committed to a mental health facility.

CONCLUSION

The protection of a patient from unwanted or

unwarranted antipsychotic medication does not require procedures designed to involve the judiciary in pre-approval of medical diagnosis and treatment. Due process is satisfied if the decision to prescribe medication, on an involuntary basis if necessary, is in fact an exercise of a licensed physician's professional judgment. The judgment of the Supreme Court of Washington requiring prior judicial approval of the modality of psychiatric treatment should be reversed.

DATED: May 9, 1989

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6

IN THE COURT OF APPEAL OF THE
STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION FOUR

In re CHARLES WOODALL,

A041054

Super. Ct.No. MH3635

Objector and Appellant.

(Solano County)

Keyhea v. Rushen (1986) 178 Cal.App.3d 526 (hereinafter Keyhea), held that state prisoners have a statutory right to refuse long-term treatment with psychotropic drugs absent a judicial determination that they are incompetent to do so. The issue in this case is whether a prisoner may be deprived of that right on the basis of a judicial determination that he is a danger to others as a result of a mental disorder. Penal Code section 2600 (hereinafter section 2600) provides that "A person sentenced to imprisonment in a state prison may, during any such period of confinement, be deprived of such rights, and only such rights, as is necessary in order to provide for the reasonable security of the institution in

which he is confined and for the reasonable protection of the public." Following Keyhea and applying section 2600, we hold that the state must prove by clear and convincing evidence not only that a mentally disordered prisoner is a danger to others, but also that there are no less intrusive means of providing for institutional security, before it may administer long-term involuntary medication over the prisoner's competent objection.

I. FACTUAL AND PROCEDURAL BACKGROUND

A. The Injunction

After the decision in Keyhea, the Superior Court for the County of Solano entered a permanent injunction specifying the conditions for "involuntary medication" of individuals confined within the jurisdiction of the California Department of Corrections. (Order Granting Plaintiffs' Motion for Clarification and Modification of Injunction and Permanent Injunction, filed October 31, 1986, in Keyhea v. Rushen, No. 67432; hereinafter, the injunction). For purposes of the injunction, "involuntary medication" means "the administration of any psychotropic, psychoactive, or antipsychotic medication or drug to any person by the use of force, discipline, or restraint," as well as the administration of any such medication or drug to a person who does not give "informed consent" as defined in the injunction.^{1/} The procedures required by the

1. The injunction defines the terms "psychotropic drugs" and/or "antipsychotic drugs" as "drugs or
(Fn. 1 cont'd. on next page.)

injunction may be outlined as follows.

Involuntary medication may be administered for more than three days-only if the professional staff of the facility in which the prisoner is incarcerated has analyzed the prisoner's condition and has found that the prisoner is, as a result of a mental disorder, "gravely disabled and incompetent to refuse medication or a danger to others, or a danger to self,"^{2/} and the prisoner has been "advised

(Fn. 1 cont'd. from previous page.)

medications used in the treatment of mental disease, mental disorder, or mental defect," including, without limitation, "thorazine, prolixin, stelazine, serentil, guide, lithium, loxitane, tindal, compazine, trilacon, repoise, mellaril, tracton, navane, haldol, moban and vesprin." "Informed consent" means that the prisoner, "without duress or coercion, clearly and explicitly manifests consent to the proposed medication to the treating physician in writing" after receiving all of the information about the treatment required by the injunction. Such information includes inter alia the "probable frequency and duration" of the treatment, "why and how it works and its commonly known risks and side effects," and the "reasonable alternative treatments." The prisoner must also be informed that he "has the right to accept or refuse the proposed treatment, and that if he consents, he has the right to revoke his consent for any reason, at any time prior to or between treatments."

2. We have no occasion in this case to review the injunction insofar as it provides for involuntary medication
(Fn. 2 cont'd. on next page.)

of the need for, but has not been willing to accept medication on a voluntary basis." The injunction defines "danger to others" in substantial accord with the criteria for six month involuntary commitments under Welfare and Institutions Code section 5300 (hereinafter section 5300).^{2/}

(Fn. 2 cont'd. from previous page.)

of prisoners found to be a "danger to self" or gravely disabled and incompetent.

3. Under section 5300, a person may be involuntarily committed to a mental health facility for a period not exceeding 180 days if any one of the following exists: "(a) The person has attempted, inflicted, or made a serious threat of substantial physical harm upon the person of another after having been taken into custody, and while in custody, for evaluation and treatment, and who, as a result of mental disorder [or mental defect], presents a demonstrated danger of inflicting substantial physical harm upon others. (1)(b) The person had attempted, or inflicted physical harm upon the person of another, that act having resulted in his or her being taken into custody and who presents, as a result of mental disorder [or mental defect], a demonstrated danger of inflicting substantial physical harm upon others. (1)(c) The person had made a serious threat of substantial physical harm upon the person of another within seven (7) days of being taken into custody, that threat having at least in part resulted in his or her being taken into custody, and the person presents, as a result of mental disorder [or mental defect], a demonstrated danger of inflicting substantial physical harm upon others." (§ 5300, subds. (a), (b), and (c).) Except for deletion of the

(Fn. 3 cont'd. on next page.)

As a consequence, mentally disordered prisoners do not constitute a "danger to others" within the meaning of the injunction or this opinion unless, on the basis of certain specified behavior, they are found to present "a demonstrated danger of inflicting substantial physical harm upon others." (§ 5300, subds. (a), (b), (c).)

Involuntary medication may continue for up to 21 additional days if the prisoner receives a "notice of certification" executed by designated medical personnel and, subject to exceptions within the control of the prisoner or the prisoner's attorney or advocate, a "certification review hearing" is held within ten days of the initial involuntary medication. The certification review hearing is conducted by a court-appointed commissioner or referee, or a "certification review hearing officer" with specified qualifications.^{3/} If the hearing officer finds "probable cause" that the prisoner is a danger to others as

(Fn. 3 cont'd. from previous page.)

bracketed language and insertion of the underlined number, the injunction repeats the foregoing language verbatim in its definition of "danger to others." For purposes of the injunction, "custody" means "confinement in a inpatient psychiatric unit uninterrupted by any period of release or transfer from such a unit."

4. The injunction spells out the prisoner's procedural rights in connection with the certification review hearing, including inter alia the right to be present, to the assistance of an attorney or advocate, and to present evidence in opposition to the certification decision.

a result of a mental disorder, then the prisoner may be medicated involuntarily for a total of 24 days following the initial involuntary medication.

Absent an emergency,^{2/} involuntary medication cannot continue for more than 24 days without a court order. The state must file a verified petition in the superior court of the county in which the prisoner is confined, alleging inter alia: the recommended course of psychiatric treatment which is considered to be medically appropriate; the threat to the health of the prisoner if authorization for the recommended course of treatment is delayed or denied by the court; the available alternatives, if any, to the course of treatment recommended; the efforts made to obtain an informed consent from the prisoner; and references to any incidents that precipitated the filing of the petition. The prisoner has the right to an expedited hearing, appointed counsel and, subject to "medical inability,"^{4/} the right to appear at the hearing.

5. The injunction states that none of the required procedures are "intended to prohibit a physician from taking appropriate action in an emergency." An "emergency" exists when there is "a sudden marked change in the prisoner's condition so that action is immediately necessary for the preservation of life or the preservation [sic] of serious bodily harm to the patient or others, and it is impracticable to first obtain consent." The maximum periods of involuntary medication permitted by the injunction include any periods of emergency medication.

6. Such inability must be established by the affidavit (Fn. 6 cont'd. on next page.)

The court may authorize involuntary medication for 23 days based on an affidavit or declaration "clearly establishing the necessity for the temporary order." Involuntary medication may be administered for up to 180 days if the court finds by clear and convincing evidence that the prisoner, as a result of a mental disorder, is a danger to others.

B. Appellant's Case

In accordance with the foregoing procedures, involuntary medication of Charles Woodall (appellant), a prisoner incarcerated at the California Medical Facility at Vacaville, was authorized for a period of up to six months based on a judicial determination that he was a danger to others as a result of a mental disorder. The record in appellant's case may be summarized as follows.

On September 24, 1987, appellant approached a correctional officer and asked to see a psychiatrist because he felt "like stabbing someone with an ice-pick, like stabbing them right in the eye." Appellant also stated that

(Fn. 6 cont'd. from previous page.)

or certificate of a licensed medical practitioner. The injunction provides that emotional or psychological instability is not good cause for the absence of the prisoner from the hearing unless, by reason of such instability, attendance at the hearing is "likely to cause serious and immediate physiological damage" to the prisoner.

he had "felt like stabbing" an inmate volunteer porter the day before. Appellant was certified for involuntary medication the next day, after he "began shouting racial slurs to several staff members," refused to return his breakfast tray, tore holes in a blanket with his teeth, placed a portion of the blanket over his head like a mask, stuck pieces of toilet paper in his nose and lay on his bed giggling. The September 25, 1987, notice of certification described appellant as "threatening and paranoid" and alleged that he was a danger to others, noting that he had twice threatened to "gauge [sic] the eyes" of a correctional officer in the preceding two days. Further involuntary medication was authorized at a certification review hearing on October 2, 1987, based on a finding that appellant "present[ed] an imminent threat of substantial physical harm to others" as a result of a mental disorder. The decision states that appellant "is hostile in manner, even after some medication; admits to threats to gouge out officer's eyes, also bizarre conduct--putting his food and clothing into toilet"

On October 15, 1987, the state filed its verified petition in the Solano County Superior Court for authorization to continue appellant's involuntary medication on the basis of his danger to others. The petition listed "Group, occupational and recreational therapy" along with psychotropic medication as "recommended courses of treatment which are considered to be medically appropriate." Under "available alternatives," however, it stated "None at present." The state obtained a temporary order for involuntary medication of appellant pending the November 5, 1987,

hearing on the petition.

The only witness at the hearing was Dr. F. George Kassebaum, who was then appellant's treating physician. Testifying as an expert in psychiatry, Kassebaum reviewed the circumstances of appellant's case, stated that he considered appellant's threats to be "very serious" and opined that appellant was "a danger to others." Kassebaum noted that appellant had improved with medication, but he did not testify unequivocally that involuntary medication was "necessary" in appellant's case,^{2/} nor did he address whether any alternative was

7. Kassebaum testified on this point as follows: "Q. Doctor, was it necessary to administer involuntary medications to this patient for his benefit and for his recovery? A. I think it was. I certainly think that this is the accepted mode of treatment. We certainly see a lot more response than when we don't use medication. Necessary is . . . is a question that . . . to be able to say necessary is . . . a little more than I can attest to . . . Q. Now, you said that . . . You were asked a question, is it, in your opinion, necessary to administer involuntarily medications to Mr. Woodall, and it sounded to me as though you were concerned about the use of the word 'necessary'? A. Yes. Looking at how we define 'necessary,' if we're willing to let a person continue to suffer and suffer and suffer from delusions and hallucinations as they did prior to the time we had no epileptic medication, then we would say, no, it's not a necessity. But I think for their comfort's sake, because I think Mr. Woodall testified he feels better now than he did when he came in, and I think without question is, as (Fn. 7 cont'd. on next page.)

available. He conceded that appellant sought psychiatric help voluntarily, was willingly taking medication as of the date of the hearing and had in fact refused medication only during a "brief interlude." In Kassebaum's view, however, this did not mean that appellant was not a danger to others or that he would continue to accept medication voluntarily. At the conclusion of the hearing, the court found by clear and convincing evidence that appellant was "demonstrably a substantial danger to others as a result of a mental disease or defect or disorder," and authorized continued involuntary medication for up to six months.

II. DISCUSSION

Appellant contends that the order for involuntary medication violates the statutory rights recognized in Keyhea, as well as his common law and constitutional rights, because it was not based on a finding of incompetence. He also argues that the findings required for involuntary medication should be based on proof beyond a reasonable doubt rather than the less rigorous standard of clear and convincing evidence.

A. Preliminary Contentions

The state contends initially that appellant's claims

(Fn. 7 cont'd. from previous page.)

he related that to me when we interviewed him on the 3rd."

must be rejected because they were not raised in the trial court or, alternatively, because they are barred by the decision in Keyhea on the grounds of res judicata or collateral estoppel. We will address these arguments before proceeding to the merits.

Although issues may not ordinarily be raised for the first time on appeal (see, e.g., Estate of Westerman (1968) 68 Cal.2d 267, 269), this case falls within the exception for issues of law arising from undisputed facts (see, e.g., Seeley v. Seymour (1987) 190 Cal.App.3d 844, 857) because there is no dispute about the findings the trial court made or the evidentiary standard it applied. The state argues that it was prejudiced by appellant's failure to object in the first instances because evidence of his incompetence could have been presented if the objection had been sustained. That point is moot, however, because the order for involuntary medication did not extend beyond six months and the state has already received the authorization it sought in this proceeding. By the same token, of course, this appeal is also moot. However, we may retain jurisdiction because the case poses "issues of public interest that are capable of repetition, yet avoiding review," and there is a "paucity of authority and interpretation" concerning the injunction. (See Conservatorship of Fadley (1984) 159 Cal.App.3d 440, 445.) Accordingly, the appeal is not barred by appellant's failure to contest the injunction in the trial court.

We also conclude that the appeal may be heard notwithstanding the decision in Keyhea, which was a taxpayers' suit against various state officials. Although

this case, like Keyhea, involves the procedures necessary to administer involuntary psychotropic medication to prisoners, it raises different issues with respect to those procedures. Keyhea determined that competent prisoners could not be denied their right to refuse psychotropic medication out of concern that their attendance at judicial competency hearings would threaten prison security, because substantial evidence indicated that this concern was unfounded. (Keyhea, supra, 178 Cal.App.3d at p. 542.) The Keyhea court was not called upon to decide whether deprivation of the right would be justified under section 2600 based on a judicial finding that a mentally disordered prisoner is a danger to others, or to address the standard of proof in connection with any such finding. Since the issues in this case are not "identical" to those "actually litigated" in Keyhea (see Levy v. Cohen (1977) 19 Cal.3d 165, 171; and In re Russell (1974) 12 Cal.3d 229, 233; see also Code Civ. Proc., § 1911) we find no basis for the application of res judicata or collateral estoppel and we need not decide whether appellant is in "privity" with the taxpayer-plaintiffs in Keyhea for purposes of those doctrines.

B. Section 5300

The premise of the state's first argument on the merits is that mental patients who are involuntarily committed under section 5300 based on a judicial determination that they are a danger to others may be medicated involuntarily for up to 180 days. Since prisoners have no greater rights than nonprisoners under Keyhea, and since the injunction simply applies the section 5300

criteria of dangerousness to prisoners, the state contends that the injunction is consistent with Keyhea insofar as it authorizes 180 days of involuntary medication of mentally disordered and dangerous prisoners. We find the premise of this argument to be unsound.

The contention that section 5300 authorizes involuntary medication is based on the following language in the statute: "Any commitment to a licensed health facility to provide treatment for the underlying causes of the person's mental disorder. (¶) Amenability to treatment is not required for a finding that any person is a person as described in subdivisions (a), (b), or (c) [the criteria for confinement under section 5300 and for finding that a prisoner is a "danger to others" under the injunction]. Treatment does not mean that the treatment be successful or potentially successful, and it does not mean that the person must recognize his or her problem and willingly participate in the treatment program." (§ 5300.) The state argues that mental patients may not refuse psychotropic medication under the foregoing provisions because they need not "willingly participate" in a "treatment program" that might include such medication.

We begin our analysis of section 5300 by noting that it is a part of the Lanterman-Petris-Short Act (LPS). For the reasons advanced in Keyhea, we accept the general proposition that LPS affords mental patients the right to refuse psychotropic medication unless they are

found to be incompetent.^{8/} The question, then, is whether the foregoing language is properly interpreted as denying that right to the class of mental patients covered by section 5300. In making that determination, we must be informed by repeated statutory admonitions that mental patients retain all rights not specifically denied to them under LPS. (See Welf. & Inst. Code, §§ 5005, 5325.1, and 5327.)

Although the language in question may be fairly susceptible of conflicting interpretations, it does not expressly provide that section 5300 patients forfeit their right to refuse treatment. Although the state has an "affirmative obligation" to provide treatment for persons committed under section 5300, the statute goes on to state that treatment programs "need only be made available to these persons." (§ 5300, emphasis added.) This statement does not purport to authorize involuntary treatment and suggests instead that no such treatment is contemplated. It thus appears that language to the effect that "treatment" does not mean a patient must "willingly participate" was added to limit the state's obligation to furnish treatment, rather than to authorize treatment over a patient's

8. That proposition may need to be reexamined depending upon the decision in Reise v. St. Mary's Hospital and Medical Center (1987) 196 Cal.App.3d 1388, review granted March 3, 1988 (S004002), which involves the rights of mental patients involuntarily committed under Welfare and Institutions Code sections 5150 (72 hours) and 5250 (14 days) to refuse psychotropic drugs in nonemergency situations.

objection.

The conclusion that section 5300 was not intended to authorize involuntary treatment is supported by a development in its legislative history. The provisions establishing and defining the state's obligation to treat persons committed under section 5300 were added to the statute in 1982. (Stats 1982, ch. 1563, § 1, pp. 6167-6168.) They grew out of Assembly Bill No. 351, 1981-1982 Regular Session. The bill was amended a number of times before passage, and at one point it contained the following language indicated in brackets: "Amenability to treatment is not required for a finding that any person is a person as described in subdivisions (a) and (b), [nor is it required for treatment of such person]." (Added By Assem. Amend. to Assem. Bill No. 351 (1981-1982 Reg. Sess.) January 4, 1982; deleted by Assem. Amend. to Assem. Bill No. 351 (1981-1982 Reg. Sess.) January 13, 1982.) If the statute had provided for treatment regardless of a patient's "amenability," then it could have been viewed as authorizing involuntary treatment. Deletion of this language suggests that section 5300 was not meant to authorize such treatment.

Under the reasoning of Keyhea, subject only to section 2600, dangerous prisoners have the same right to refuse treatment as dangerous mental patients. Therefore, since mental patients found to be dangerous under section 5300 retain the right of refusal notwithstanding the state's "affirmative obligation" to treat them, mentally disordered prisoners who are dangerous also retain that right notwithstanding the state's obligation to treat their mental

illness (see Estelle v. Gamble (1976) 429 U.S. 97, 104 [deliberate indifference to serious medical needs of prisoners violates Eighth Amendment]). For all of the foregoing reasons, involuntary medication of mentally disordered prisoners who are dangerous but competent cannot be justified by reference to section 5300 or the state's obligation to provide treatment. It can only be justified as a prison security measure under section 2600.

C. Section 2600

Claims under section 2600 involve "a three -step inquiry: (1) Are any 'rights' implicated? (2) If they are, does a 'reasonable security' problem exist which might permit a deprivation of rights under the statute? (3) If so, to what extent are deprivations of those rights 'necessary' to satisfy reasonable security interests[?]" (In re Arias (1986) 42 Cal.3d 667, 689-690.) Involuntary medication of prisoners based solely on a finding of dangerousness obviously "implicates" their statutory right, identified in Keyhea, supra, 178 Cal.App.3d at p. 530, to refuse such medication absent a finding of incompetence.^{2/} It is also apparent that a mentally disordered prisoner who presents a "demonstrated danger of inflicting substantial physical harm upon others" is a "reasonable security problem." The record in this case supports the trial

9. Since we decline to reexamine Keyhea's conclusion that prisoners have this statutory right, we need not consider whether the right has a common law or constitutional basis. (Keyhea v. Rushen, supra, 178 Cal.App.3d at p. 541.)

court's finding that appellant was a danger to others within the meaning of the injunction. Therefore, the only question under section 2600 is whether long term involuntary medication of appellant was "necessary" for purposes of prison security.

Since, "[b]y definition, the 'necessary' standard requires that a security measure be the least intrusive possible of inmates' rights yet flexible enough to satisfy the security need" (In re Arias, supra, 42 Cal.3d at p. 691), the danger to others posed by mentally disordered prisoners justifies their involuntary medication only if there is no less intrusive means of insuring prison security. Prisoners' rights under section 2600 must be determined with reference to the rights of nonprisoner (Ibid.), and mental patients in California are guaranteed the right to be treated "in ways that are least restrictive of the personal liberty of the individual" (Welf. & Inst. Code, § 5325.1, subd. (a)). We conclude that the injunction is flawed insofar as it authorizes long-term involuntary medication of dangerous but competent prisoners absent a judicial finding that a less restrictive alternative does not exist.

The state objects that at present there is no "generally accepted medical alternative" other than psychotropic medication to "stabilize" an acutely psychotic patient. We have already determined, however, that involuntary medication may not be imposed over a competent objection, and we are concerned at this point with the state's obligation to maintain the security of its prisons rather than the medical efficacy of the proposed

treatment. For purposes of prison security, the only feasible alternatives to involuntary medication may be physical restraints or isolation, but we are unable to conclude that as a matter of law these alternatives are "more intrusive" than psychotropic drugs from the standpoint of a competent prisoner who does not want to be medicated. Although solitary confinement is known to cause adverse side effects (see Benjamin & Lux, Solitary Confinement as Psychological Punishment (1977) 13 Cal. Western L. Rev. 265, 266-277), the same is true of psychotropic drugs (see Keyhea, supra, 178 Cal.App.3d at p. 531) and, in any event, where a mentally ill person poses a danger to others, "there is no reason why . . . every attempt should not be made to treat the person in the least restrictive manner. In some cases this may mean physically, rather than chemically, restraining him; in others, perhaps, just the opposite." (Weiner, Treatment Rights in Brakel et al., The Mentally Disabled and the Law (3d ed. 1985) at p. 348.)

The state also appeals to cases involving mental patients' capacity to consent to convulsive treatment under Welfare and Institutions Code section 5326.7, noting that the courts have interpreted this statute to preclude judicial review of medical decisions that such treatment is the "least drastic alternative available." (See Conservatorship of Fadley, supra, 159 Cal.App.3d at p. 446; see also Conservatorship of Waltz (1986) 180 Cal.App.3d 722, 733, fn. 13 ["it is not the role of the courts to second-guess the medical opinion of the patient's physician"].) Our case, however, does not involve capacity to consent and we are called upon to apply a statute which, by definition,

requires an analysis of less intrusive alternatives.

Although judicial involvement is required by section 2600 in this context whether or not such involvement is good policy, inquiry into less restrictive alternatives may help prevent the improper use of involuntary medication for the convenience rather than the "reasonable security" of prison staff. A number of cases have cited the potential for abuse of psychotropic medication (see, e.g., Davis v. Hubbard (N.D. Ohio 1980) 506 F.Supp. 915, 927 [describing widespread use of psychotropic drugs for punishment and for convenience of hospital's staff]. The state responds that there is "no evidence in the present case that appellant, or any other inmate in the Department of Corrections, was ever administered psychotropic medications, voluntarily or involuntarily, for the convenience of staff." However, when asked whether involuntary medication would be "beneficial" in appellant's case, the state's witness responded that "the involuntary is a safeguard for the individual" because the "tracking of taking medication in CMF" is "much better when its on involuntary," as if accurate recordkeeping were a sufficient justification for involuntary medication. The need for proof on the question of alternatives may also help eliminate ambiguous pleadings like the petition in appellant's case, which alleged that there was no alternative to involuntary medication even though other forms of therapy were "medically appropriate."

It bears emphasis, however, that a less intrusive alternative is required under section 2600 only if it is sufficient to "satisfy the security need" of the institution.

(*In re Arias*, *supra*, 42 Cal.3d at p. 691.) Certain of the alternatives suggested by appellant such as withdrawal of good time credits and loss of privileges are in the nature of punishment, and they would not address the security risk posed by a mentally disordered inmate who is a danger to others within the meaning of the injunction. On the other hand, dangerous prisoners who are isolated or physically restrained may not properly claim that they are being "punished" for their mental illness if they refuse psychotropic medication and such medication is the only other way to control their violent behavior. In view of the state's legitimate security interest, if such prisoners agreed to take psychotropic medication only when faced with the choice of isolation or physical restraint they could not complain, by analogy to LPS, that such consent was improperly obtained. (See Welf. & Inst. Code, § 5326.5, subd. (b) [physician may not solicit consent to treatment by threatening patient with a "more restricted setting"].)

Section 2600 involves a balancing of "the state's security interests against the rights of detainees." (*In re Arias*, *supra*, 42 Cal.3d at p. 691.) Although our focus is on detainees' rights, we do not mean to suggest that the state cannot take whatever security measures are necessary to guard against the threat posed by prisoners like appellant. Based on the foregoing discussion, we require only that less intrusive alternatives be considered if the safeguard is to be involuntary medication, and that such alternatives be employed if they will be adequate from the standpoint of institutional security.

D. Standard and Burden of Proof

Appellant contends that proof beyond a reasonable doubt should be required before a prisoner is found to be a danger to others under the injunction. The state responds that the *Keyhea* plaintiffs asked for application of a clear and convincing evidence standard in proceedings for prisoners' involuntary medication, and that this aspect of the injunction should not be disturbed. Each of these standards of proof has been applied in analogous situations. (Compare *Conservatorship of Roulet* (1979) 23 Cal.3d 219, 235 [proof beyond a reasonable doubt required to establish LPS conservatorship]; with *Conservatorship of Sanderson* (1980) 106 Cal.App.3d 611, 621 [clear and convincing evidence required to establish probate conservatorship]; *Lillian F. v. Superior Court* (1984) 160 Cal.App.3d 314, 324 [clear and convincing evidence required to find that LPS conservatee lacks capacity to refuse convulsive treatment]; and *Maxon v. Superior Court* (1982) 135 Cal.App.3d 626, 633-634 [clear and convincing evidence required to establish medical necessity for hysterectomy of LPS conservatee].) Appellant also cites *Guardianship of Roe* (Mass. 1981) 421 N.E.2d 40, 60-61, which held that proof beyond a reasonable doubt is required in proceedings for involuntary medication of wards of the state of Massachusetts, but we note that this opinion did not address "the question of whether and to what extent the State interest in institutional order and safety may be capable of overwhelming the right of an involuntarily committed individual to refuse medical treatment" (*Id.* at p. 61, fn. 23; emphasis original).

Clear and convincing evidence is an intermediate standard of proof requiring more than a preponderance of the evidence (see generally Lillian F. v. Superior Court, supra, 160 Cal.App.3d at p. 320), and we believe it strikes the most appropriate balance between the state's interest in institutional security and the rights of prisoners who are mentally disordered and dangerous. There is no provision for jury trials in these proceedings, and no reason to doubt the trial court's ability to distinguish evidence that is clear and convincing from that which merely predominates. Accordingly, we affirm the injunction insofar as it requires the state to prove by clear and convincing evidence that mentally disordered prisoners are a danger to others.

We hold, however, that long-term involuntary medication of such prisoners may not be authorized unless the state can also show, by clear and convincing evidence, that there is no less intrusive way to provide for institutional security. Although the state contends that it should not "be put in the position of having to prove a negative," such proof is always necessary under section 2600, where the state bears the "burden of proving the absence of lesser drastic means . . . [¶] to further an objectively reasonable security need." (In re Arias, supra, 42 Cal.3d at p. 697, fn. 34.) As a practical matter, we do not anticipate that this additional proof will significantly affect the state's burden in these cases. If the record in this instance is any indication, the only witness is likely to be the state's physician, and there is no reason why that expert should not address the allegation in the state's

petition that there is no alternative to involuntary medication.

III. DISPOSITION

We have determined that the injunction is deficient insofar as it allows long-term involuntary medication of mentally disordered prisoners on the basis of their danger to others, without clear and convincing evidence that there are no less intrusive means of maintaining institutional security. For purposes of this decision, "long-term" medication is medication beyond the maximum period of involuntary medication presently permitted under the injunction in the absence of a court order. Since the state alleged but did not prove the absence of any alternative in appellant's case, the order authorizing his involuntary medication cannot be sustained.

Considerations of public policy militate against suspension of involuntary medication of prisoners already determined to be a danger to others pursuant to the injunction, and considerations of foreseeability and reliance dictate that the state not be required to reopen proceedings already concluded with respect to such prisoners. (See generally Crasher v. Mobil Oil Corporation (1988) 198 Cal.App.3d 389, 398.) To the extent that our decision affects the rights of other prisoners like appellant, it is to be applied prospectively from the date it becomes final.

The order is reversed and the case is remanded for further proceedings consistent with this opinion.

Perley, J.

We Concur:

Poche, Acting P.J.

Channell, J.

(P. v. Woodall, A041054)

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(In re Charles Woodall, A041054)

AMICUS CURIAE

BRIEF

No. 88-599

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IN THE
Supreme Court of the United States

OCTOBER TERM, 1988

STATE OF WASHINGTON, *et al.*,
Petitioners,

v.

WALTER HARPER,
Respondent.

On Writ of Certiorari to the
Washington Supreme Court

AMICUS CURIAE BRIEF OF
THE AMERICAN PSYCHOLOGICAL ASSOCIATION
IN SUPPORT OF RESPONDENT

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OCTOBER TERM, 1988

No. 88-599

STATE OF WASHINGTON, *et al.*,
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**AMICUS CURIAE BRIEF OF
THE AMERICAN PSYCHOLOGICAL ASSOCIATION
IN SUPPORT OF RESPONDENT**

STATEMENT OF INTEREST OF AMICUS CURIAE

The American Psychological Association (APA) has been the principal professional association of psychologists in the United States since 1892. It now has more than 70,000 members, including the vast majority of psychologists with doctorates from accredited universities. APA has Divisions devoted to Psychopharmacology, Clinical Psychology, and other subjects germane to this case. APA members serve many patients who have been or may be incarcerated. APA members have a substantial interest in the effects of antipsychotic drugs on such persons, as well as a broader ethical and professional interest in ensuring that mentally ill persons are treated in an appropriate manner.¹

¹ Letters from all parties consenting to the filing of this *amicus curiae* brief have been filed with the Clerk of the Court.

SUMMARY OF ARGUMENT

This case raises the issue of whether due process requires that a prisoner receive an impartial hearing before he can be forced to take potent, mind-altering drugs that themselves cause disabling and potentially incurable disorders. The answer clearly is yes. Because antipsychotic drugs have grave effects, inherent potential for abuse, and an actual history of indiscriminate use by the psychiatric profession, forcible administration of these drugs requires review by an independent decisionmaker in a manner comporting with due process.

The antipsychotic drugs at issue have powerful effects on a person's ability to think and feel, and on his sense of self. These drugs also cause disabling, incurable, and often unpredictable disorders,² including akathisia (repetitive, irresistible tapping-type movements), dystonia (severe rigidity or spasms of the upper body, writhing and grimacing), and neuroleptic malignant syndrome, a condition that can be fatal.³ In about one-fourth of the cases, these drugs cause tardive dyskinesia, a condition that can disfigure and disable a prisoner long after his penal debt has been paid. See Section I.A., *infra*.

² See *Mills v. Rogers*, 457 U.S. 291, 293 n.1 (1982); *Rennie v. Klein*, 462 F. Supp. 1131, 1138 (D. N.J. 1978), *supplemented*, 476 F. Supp. 1294 (D. N.J. 1979), *modified and remanded*, 653 F.2d 836 (3d Cir. 1981) (*en banc*), *vacated and remanded*, 458 U.S. 1119 (1982), *on remand*, *aff'd and remanded*, 720 F.2d 266 (3d Cir. 1983) (*en banc*); *In Re Boyd*, 403 A.2d 744, 752 n.13 (D.C. 1979). See also A. Schatzberg and J. Cole, *Manual of Clinical Psychopharmacology* 87-102 (1986); Jeste, Iager, and Wyatt, "The Biology and Experimental Treatment of Tardive Dyskinesia and Other Related Movement Disorders," in 8 *American Handbook of Psychiatry* 536, 537-539 (Berger and Brodie, eds. 2d ed. 1986).

³ See generally Addonizio, *et al.*, "Neuroleptic Malignant Syndrome: Review and Analyses of 115 Cases," 22 *Biological Psychiatry* 1004 (1987); Pearlman, "Neuroleptic Malignant Syndrome: A Review of the Literature," 6 *Journal of Clinical Psychopharmacology* 257 (1986); Hollister, "Antipsychotics and Antimanic Drugs," in *Review of General Psychiatry* 596 (Goldman ed. 1984).

Respondent Harper already has developed some of these disorders, including dystonia and akathisia. Petitioner's Appendix ("Pet. App.") B-8. No one can know whether he will develop additional side effects of antipsychotic drugs; but if he does, they are likely to be incurable. See Section I.A., *infra*. Unless there is a formal determination that he is incompetent to make decisions about his own treatment, or unless he is imminently dangerous, Mr. Harper should have the right to refuse drug treatments that jeopardize his current and long-term health.

Involuntary medication is usually accomplished by restraining the inmate while he is given an intra-muscular or subcutaneous injection with a hypodermic needle. Sometimes there are repeated, ineffective needlesticks, bruises, and other injuries. As noted, the medications used can cause severe disorders. These disorders can be life-long, constituting a deprivation of liberty far beyond simple custodial confinement for the term of the criminal sentence. Accordingly, the American Psychological Association submits that involuntary medication is a "major change in the conditions of confinement,"⁴ and is "qualitatively different from the punishment characteristically suffered by a person convicted of a crime."⁵ As this Court held in *Vitek v. Jones*, "the stigmatizing consequences of a transfer to a mental hospital . . . [and] subjection of the prisoner to mandatory behavior modification as a treatment for mental illness, constitute the kind of deprivations of liberty that requires procedural protections." 445 U.S. at 494. Surely forcible drugging requires no less.

Given that a competent and objecting prisoner has a constitutional right not to be drugged without due process, the issue becomes what process is due. Under this Court's rulings, such action requires a hearing before a truly independent, unbiased decisionmaker—either a court or a properly constituted administrative body.

⁴ *Wolff v. McDonnell*, 418 U.S. 539, 571-572 n.19 (1974).

⁵ *Vitek v. Jones*, 445 U.S. 480, 493 (1980).

The State and its associated amici essentially argue⁶ that prisoners are incompetent to decide whether to accept drugs and that even if they are competent, "the concept of patient preference . . . is essentially irrelevant";⁷ that psychiatrists always make benevolent and wise decisions; and that courts should write psychiatrists a blank check to force these drugs upon patients. But each of these arguments is unsupportable.

First, most prisoners—including Mr. Harper—have never been found to be legally, medically, or psychologically incompetent to consent (or refuse to consent) to treatment. The psychiatrists' callous declaration that patients' consent to treatment is "irrelevant" flouts long-settled ethical and legal rules on the treatment of prisoners. Second, the scientific literature, as well as scores of pending lawsuits, show that psychiatrists, far from acting wisely, often prescribe antipsychotic drugs indiscriminately, risking serious and irreparable harm to patients.⁸ As a psychiatrist has written, "[l]itigation from patients suffering from TD [tardive dyskinesia] is expected to explode within the next five years. Some psychiatrists and other physicians continue to minimize the seriousness of TD . . . [despite] continual warnings."⁹

⁶ See Brief of Petitioners ("Pet. Br.") at 24, 29, 30; Brief of the United States as Amicus Curiae Supporting Petitioners ("U.S. Br.") at 3-5; Brief for the American Psychiatric Association and the Washington State Psychiatric Association as Amici Curiae ("APA/WSPA Br.") at 21; Brief Amici Curiae of Washington Community Mental Health Council, *et al.* ("WCMHC Br.") at 18-20.

⁷ APA/WSPA Br. at 21.

⁸ The findings in the scientific literature, discussed in Sections I.A and I.B, *infra*, are confirmed by a growing number of malpractice suits against psychiatrists for harm due to abuse of antipsychotic drugs. See, e.g., Joseph T. Smith, *Medical Malpractice: Psychiatric Care* § 5.17 (1986 and Supp. 1988, App. 5-1); R. Simon, *Clinical Psychiatry and the Law* 60-74 (1986); Gualtieri, Sprague, and Cole, "Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic Treatment," 14 *J. Psychiatry and Law* 187 (1986).

⁹ Simon, *supra* n.8, at 74.

Third, this Court and the lower courts repeatedly have noted the unreliability of psychiatric judgments, and have rejected the psychiatric profession's demands for unlimited discretion.¹⁰ Finally, determining whether antipsychotic drugs should be forced on a patient requires a weighing not only of medical factors (such as the anticipated benefit and the medical risk to the prisoner), but also of correctional needs (the degree of risk to others and possible alternative precautions) and the prisoner's liberty interest—which are *not* medical determinations.

We do not assert that the entity weighing these varied factors must be a court. It might also be a properly constituted administrative body, following fair procedures, and calling upon unbiased expertise.

But such a fair process surely did not occur in this case. The review panel was comprised of one administrator from the prison Special Offender Center ("SOC") and two SOC professional staff—all of whom presumably would tend to do what their institutional colleagues desired. Mr. Harper was told the basis of the medication order twenty-four hours in advance and advised to "prepare" for a hearing. He had no right to assistance of counsel, even though the staff believed he was seriously mentally ill. Rules of evidence did not apply. The panel of "unbiased" decisionmakers consulted with SOC staff about the case outside the hearing room, depriving Mr. Harper of the opportunity to respond adequately and giving him reason to believe the decision was predetermined. Subsequent SOC review panels (which authorized continued forced medication) could include the very physician who ordered medication in the first place. These features taken together clearly establish that the hearing process was not fundamentally fair and unbiased.

Forced drugging should occur only if a reasonably independent and unbiased decisionmaker concludes that it

¹⁰ See, e.g., *Estelle v. Smith*, 451 U.S. 454 (1981); *O'Connor v. Donaldson*, 422 U.S. 563 (1975); *Jackson v. Indiana*, 406 U.S. 715 (1972); *Rennie v. Klein*, *supra*.

is warranted, based upon evidence from diverse professionals (such as internists and psychologists) who have no vested interest in using antipsychotic drugs. Forced drugging is warranted only if the prisoner is incompetent or imminently dangerous, if the medication is likely to be effective, if non-drug therapies have been objectively explored, and if forced medication is truly needed for the welfare of the prisoner or others.

ARGUMENT

I. THE STATE AND ITS AMICI IGNORE WARNINGS ABOUT ANTIPSYCHOTIC DRUGS IN CURRENT MEDICAL LITERATURE.

Recent research reveals that previous reports significantly underestimated the prevalence, permanence, and severity of the disabling disorders caused by antipsychotic (neuroleptic) drugs. Although these drugs appear to be effective in alleviating the symptoms of certain mental disorders, primarily schizophrenia, they should not be used indiscriminately. It is alarming that both the State and its amici ignore the dangers of antipsychotic drugs. The persistent disregard of factual evidence by both the State and the psychiatric profession discredits their contention that they can unquestioningly be trusted to use unbiased clinical judgment in prescribing such drugs for prisoners.

A. Antipsychotic Drugs Often Cause Dangerous and Largely Incurable Disorders.

The disorders caused by antipsychotic drugs range in severity from mildly disturbing to lethal. The less severe ones include nausea, skin rashes, restlessness, muscle stiffness, dry mouth and congestion, diminished energy, and suppression of personality. More serious disorders include vomiting, diarrhea, blurred vision, nocturnal confusion, tremors and spasms, shuffling walk, and inability to sit still.¹¹ The truly grave risks presented by these

¹¹ The major antipsychotic drugs include Haldol, Mellaril, Navane, Compazine, Prolixin, and Thorazine. For a description of side effects

drugs include liver damage, changes in heart rate (possibly resulting in cardiac arrest), convulsions, acute dystonia (fixed, involuntary rigidity due to muscle spasms), neuroleptic malignant syndrome (which can lead to death from cardiac dysfunction)¹²—and tardive dyskinesia.

Tardive dyskinesia is characterized by bizarre, uncontrollable movements of the face (lip smacking, chewing, protruding tongue, grimacing) and similar rhythmic, involuntary movements of the trunk, arms and legs.¹³ At times it occurs in a mild form, but its more serious form can include severe physical and other effects:

Physical complications range from severe respiratory disturbances, characterized by irregularities in respiratory rate, depth, and rhythm accompanied by involuntary grunting, snorting, and gasping noises; or severe gastrointestinal dyskinesia with persistent vomiting, aerophagia, retching, and paroxysmal contraction and distention of the abdominal wall; to less severe but more frequent and still disturbing swallowing disorders, hyperkinetic dysarthria, loosening of teeth, and traumatic ulcerations of the oral mucosa, which may become infected.

Psychosocial sequelae may range from embarrassment, anxiety, guilt, shame, and anger, to severe, full-blown reactive depression, decompensation of psychosis, and even suicide. Dyskinesia can result in

they can cause, see generally *Physician's Desk Reference* (43d ed. 1989) ("PDR"), at 1236 (Haldol), 1882 (Mellaril), 1785 (Navane), 2042 (Compazine), 1639 (Prolixin), and 2071 (Thorazine).

¹² See generally PDR, *supra* n.11, at 1968 ("a potentially fatal symptom complex sometimes referred to as Neuroleptic Malignant Syndrome (NMS) has been reported in association with antipsychotic drugs. Clinical manifestations of NMS are hyperpyrexia [feverishness], muscle rigidity, altered mental status and evidence of autonomic instability (irregular pulse or blood pressure, tachycardia, diaphoresis [profuse perspiration] and cardiac dysrhythmias").

¹³ See generally Jeste, Iager, and Wyatt, *supra* n.2, at 537-538.

a social and/or occupational handicap and stigmatization.¹⁴

As devastating to a patient as these disorders are, even more disturbing is the fact that once symptoms become manifest, it is unlikely that they will disappear—even if medication is discontinued. While the State and its amici rely principally on the American Psychiatric Association's Task Force Report on Tardive Dyskinesia,¹⁵ that report is based on data developed between the 1950s and 1970s, which no longer represent the best scientific judgment. More recent published reports, which include analysis of all of the prior studies, show that the prevalence of tardive dyskinesia ("TD") among patients treated with neuroleptics is increasing at an alarming rate, as shown in the chart below:

*Increasing Prevalence of Tardive Dyskinesia Among Chronically Ill Psychiatric Inpatients Treated With Neuroleptics*¹⁶

Period	1960-1965	1966-1970	1971-1975	1976-1980
No. of Studies	3	16	6	12
No. of Patients	821	6800	2211	3048
Prevalence of TD (%)	5.5%	14.6%	20.2%	25.6%

Thus, an impressive body of recent research shows that tardive dyskinesia is far from the minimal risk that the State and its amici suggest. For long-term patients such as Mr. Harper, the chance of suffering this potentially devastating disorder is greater than one in four.¹⁷ The

¹⁴ *Id.* at 541.

¹⁵ American Psychiatric Association Task Force on Late Neurological Effects of Antipsychotic Drugs, Report 18 *Tardive Dyskinesia* (1980). (See, e.g., Table 6 at 26 at Table 14 at 102-103.)

¹⁶ Jeste, Iager and Wyatt, *supra* n.2, at 539. Richard Jed Wyatt, M.D., is Chief of the Neuropsychiatry Branch and also Chief of the Psychopharmacology Section of the National Institute of Mental Health.

¹⁷ *Id.* See also Gualtieri, Sprague, and Cole, *supra* n.8, at 187; Baldessarini, "Clinical and Epidemiologic Aspects of Tardive Dyskinesia," 46(4) *J. Clin. Psychiatry* 8 (1985).

consistent escalation of the reported incidence of tardive dyskinesia suggests that when studies are performed in the coming years, the incidence may well be still higher. Other troubling aspects of tardive dyskinesia are that it is impossible to predict which patients will develop the disorder, and that the disorder is reversible in only one-third of the patients who suffer its consequences.¹⁸

B. Indiscriminate and Incorrect Use of Antipsychotic Drugs Exacerbates the Problem.

A patient's risk of suffering from tardive dyskinesia is further heightened by several disturbing features of the disorder and psychiatric practice. First, onset of the disorder often is masked by the very drugs that cause it, so that symptoms do not appear until the medication is stopped, and the disorder is so advanced that it cannot be cured.¹⁹ Second, psychiatrists often fail to recognize the incipient symptoms of harm. A 1987 study found that attending psychiatrists failed to recognize symptoms of tardive dyskinesia in about 90% of the cases.²⁰ Still worse, neurologic side effects—particularly akathisia—are sometimes misdiagnosed as agitation or psychosis, with the result that the psychiatrists then increase the dosage of the very drugs that cause the disorders.²¹

¹⁸ Jeste, Iager, and Wyatt, *supra* n.2, at 560:

We estimate that in approximately one-third of these patients in whom neuroleptics are stopped, TD will disappear. The remaining two-thirds of these patients will have persistent TD. . . . To date, there is no proven specific curative treatment for persistent TD. [Emphasis added.]

Accord Baldessarini, *supra* n.17.

¹⁹ Jeste, Iager, and Wyatt, *supra* n.2, at 560.

²⁰ Weiden, et al., "Clinical Nonrecognition of Neuroleptic-Induced Disorders: A Cautionary Study," 144(9) *Am. J. Psychiatry* 1148, 1150 (1987). A similar study found a 75% rate of nonrecognition of tardive dyskinesia in a Veterans Administration teaching hospital. Hansen, Casey, and Weigel, "TD Prevalence: Research and Clinical Differences," *New Research Abstracts*, 139th Annual Meeting of the American Psychiatric Association (1986).

²¹ Weiden, et al., *supra* n.20, at 1151-52.

Although antipsychotic medications can and do ameliorate the symptoms of *certain* mental illnesses, the seriousness of their adverse effects dictates that they be used only for conditions for which they have proven effective. The 1986 *Manual of Clinical Psychopharmacology* warns:

Maintenance antipsychotic therapy in non-schizophrenic patients is not, generally, a good idea The risk of dyskinesia is real, and the burden is on the clinician to prove that maintenance therapy was, in fact, necessary and effective.

* * *

In conditions such as depression, anxiety, personality disorder, or organic brain syndromes where efficacy is not firmly established, other drug therapies or no drug therapy may be preferable.²²

The use of these neuroleptic drugs may be appropriate to treat schizophrenia, paranoia, childhood psychosis, and certain neuropsychiatric disorders such as Tourette syndrome and Huntington's chorea.²³ The vast majority of mentally ill prisoners, however, *do not suffer from such disorders*. Instead, most of these inmates have a personality disorder or a history of alcohol or drug abuse, as shown in the table below:

*Percent of Mentally Ill Prisoners With Specific Diagnoses*²⁴

Prison Site	Schizophrenia or Schizophreniform	Depression or Manic Depression	Antisocial Personality or Personality Disorder	Substance Abuse
Washington	6.6%	14.6%	44%	66%
Oklahoma	5.9%	unreported	35%	25%
Michigan	2.8%	8.9%	50%	47%

²² Schatzberg and Cole, *supra* n.2, at 86, 87.

²³ Jeste, Iager and Wyatt, *supra* n.2, at 559. Even with such disorders, periods of nonmedication and low continuous dosages are advisable.

²⁴ Source: Jemelka, Trupin and Chiles, "The Mentally Ill in Prisons: A Review," 40(5) *Hosp. and Community Psychiatry* 481, 482-483 (1989).

Thus, since most mentally ill prisoners have precisely the kind of disorders that "*have not been found to respond to psychopharmacologic treatment*,"²⁵ there should be little need for chronic use of antipsychotic drugs in penal institutions. If psychiatrists are using these drugs for the wrong disorders, the practice should not be sanctioned.²⁶

An antipsychotic drug should be administered only after a thorough diagnostic and psychological workup and "only when it is the drug of choice for a well-specified clinical condition."²⁷ Although Mr. Harper reportedly suffered at times from manic-depression, and the record mentions many drugs he was forced to take, it does not show that he ever was treated with lithium, which psychopharmacologists and psychiatrists view as the "overwhelming treatment of choice for patients suffering from manic-depression."²⁸ While a patient exhibiting manic excitement properly may be given both lithium and an antipsychotic drug for a brief period until the mania subsides, "the effectiveness of long-term treatment of manic-depression with an antipsychotic remains questionable at best."²⁹

The indiscriminate approach to treatment, in which individuals like Mr. Harper are forced to take a variety of potent drugs without any clear diagnosis of their mental

²⁵ Schatzberg and Cole, *supra* n.2, at 21-22 (emphasis supplied).

²⁶ Cf. *Davis v. Hubbard*, 506 F. Supp. 915, 926 (N.D. Ohio 1980) ("Psychotropic drugs are not only overprescribed; they are also freely prescribed. . . . Such widespread use of psychotropic drugs, both in terms of the number of patients using drugs and the dosages that they receive is not . . . however, necessarily supported by any sound medical course of treatment. [I]t is countertherapeutic and can be justified only for . . . the convenience of the staff or for punishment").

²⁷ Jeste, Iager, and Wyatt, *supra* n.2, at 559; see also Schatzberg and Cole, *supra* n.2, at 86-87.

²⁸ Smith, *supra* n.8, § 5.15 at 128. See also *Rennie v. Klein*, 462 F. Supp. at 1138 ("Lithium carbonate is now established as the most effective treatment available for mania").

²⁹ Smith, *supra* n.8, § 5.13 at 123-124.

disorder, is bad medicine. Encouraging it would be bad law. As one court observed:

[A]t various times during plaintiff's prior hospitalizations, diagnoses of both schizophrenia and manic depression were offered. . . . [The] lack of certainty about causation and physiopathology demonstrates the tentativeness of much psychiatric diagnosis as compared to the usual physical diagnosis.

* * *

[T]he testimony in this case underscores the fact that psychiatric diagnosis and therapy is uncertain, with great divergence of opinion in any given case. . . . This also weighs toward leaving the final decision with the patient rather than deferring to the doctors. [*Rennie v. Klein*, 462 F. Supp. at 1145 (citations omitted).]

Given their potency and serious adverse consequences, antipsychotic drugs should be administered (even to consenting patients) with care and restraint. This requires, at a minimum, a thorough evaluation to identify any alternative treatable basis for the behavioral symptoms and to ensure that the use of antipsychotic drugs is not inadvisable due to the presence of other complications. Equally important, the prescribing psychiatrist should be required to document evidence supporting a diagnosis for which the proposed drug regimen is recognized as effective. Forcing drugs that are likely to be ineffective for the condition at issue is destructive and pointless.³⁰

Finally, the dose of the prescribed drug should be the lowest dose that is effective. Unfortunately, the literature reveals that in the decade from 1973 to 1982, the average dose of neuroleptic drugs approximately *doubled* in many psychiatric facilities, although it "has not been documented . . . whether patients need or benefit from such high doses of neuroleptics."³¹ In fact, psychiatrists some-

³⁰ Smith, *supra* n.8, § 5.20 at 140.

³¹ Reardon, *et al.*, "Changing Patterns of Neuroleptic Dosage Over a Decade," 146 *Am. J. Psychiatry* 726, 727, 729 (1989).

times prescribe five to ten times the necessary dose of antipsychotic drugs.³² This results in no increase in effectiveness, but a significant increase in risks. As one expert warns:

Given that there is no satisfactory treatment for tardive dyskinesia, it is reasonable . . . to try to minimize risks of tardive dyskinesia by thoughtful and conservative long-term use of neuroleptic medications for clear indications (chronic psychotic illness that *responds* to treatment), and in the lowest effective doses, which may be as low as 10%-20% of those now in common use in this country.³³

We have searched the record of this case in vain for evidence that these basic precautions were taken before Mr. Harper was forced to risk his long-term health by taking antipsychotic drugs. The record reveals no discussion of specific diagnoses, lower drug dosages, less risky medications, or the benefits of drug-free respite periods, all of which are standard medical considerations. The minutes of the SOC review committee's meetings apparently include only the conclusory statement that "the committee found that, as a result of mental disease or disorder, Mr. Harper was a danger to others." Pet. App. A-3, B-3. Although periodic review of each case is required, it does not appear that periodic examinations and laboratory tests are either required or presented during such reviews. *Id.* Nor is there evidence that psychological or behavioral therapies were tried—or even considered.

In sum, antipsychotic drugs have both an inherent potential for abuse and an actual history of indiscriminate use by the psychiatric profession. In this respect they

³² Baldessarini, *supra* n.17, at 10 ("there is growing evidence that typical maintenance (or even short-term) regimens involve doses of neuroleptics that are much greater than necessary for many patients, perhaps by a factor of 5-10").

³³ Baldessarini, *supra* n.17, at 10-11 (emphasis in original). See also Reardon, *et al.*, *supra* n.31, at 728-729.

are similar to psychosurgery and electroshock therapy, highly invasive treatments which psychiatrists embraced enthusiastically and used indiscriminately—until their tragic effects became publicized and their use was curtailed by legislative, judicial, and scientific pressure.³⁴ Because many psychiatrists will not heed the warnings in the scientific literature as to the dangers and misuse of neuroleptic drugs, independent and unbiased decisionmakers should decide whether orders for forced medication are justified. Even some psychiatrists acknowledge that:

Placing unbridled discretion in the hands of a single clinician has often led to unskillful and at times unfortunate use of medications. This is particularly true in some of our public facilities, which historically have had difficulties recruiting and supporting competent clinicians.³⁵

Moreover, as many courts have found, prisons present unique possibilities for distortion of clinical judgment by punitive, retaliatory, or other improper motivations.³⁶ Thus, even more than patients in private hospitals, prisoners need the protection of unbiased decisionmakers.

³⁴ See generally E. Valenstein, *Great and Desperate Cures: The Rise and Decline of Psychosurgery and Other Radical Treatments for Mental Illness* (1986); P. Breggin, *Electroshock: Its Brain-Disabling Effects* (1979).

³⁵ Appelbaum, "The Right to Refuse Treatment with Antipsychotic Medications: Retrospect and Prospect," 145(4) *Am. J. Psychiatry* 413, 418 (1988).

³⁶ "In *Nelson, Pena, and Mackey*, the courts found that the drugs were used improperly and for punishment rather than as part of an ongoing psychotherapeutic program." *Rennie v. Klein*, 462 F. Supp. at 1143, citing *Nelson v. Heyne*, 355 F. Supp. 451, 455 (N.D. Ind. 1972), *aff'd* 491 F.2d 352 (7th Cir.), *cert. denied*, 417 U.S. 976 (1974); *Pena v. New York State Div. for Youth*, 419 F. Supp. 203, 207 (S.D.N.Y. 1976); and *Mackey v. Procunier*, 477 F.2d 877 (9th Cir. 1973). See also *Bee v. Greaves*, 744 F.2d 1387, 1390 (10th Cir. 1984) ("jail officers administered Bee's medication forcibly by injection for the express purpose of intimidat[ing] him so he wouldn't refuse the oral medication anymore"), *cert. denied*, 469

II. Forcible Administration of Antipsychotic Drugs Implicates Basic Liberty Interests.

A. Prisoners Usually Have a Right to Refuse Invasive and Dangerous Therapies.

It is beyond reasoned dispute that forcing drugs on an unwilling prisoner at least impinges upon constitutionally protected liberty interests. Administering drugs to an individual who is actively resisting is usually accomplished by physically restraining the prisoner while a hypodermic needle is forced beneath the skin (subcutaneous injection) or into a large muscle (intramuscular injection). Often the process results in repeated needlesticks, bruises, pools of medication in tissue, and further efforts to insert the needle.

Moreover, the psychotropic drugs that are administered have a powerful effect on the prisoner's mental state, awareness, and sense of self. For some patients, these drugs may be helpful—even essential—in restoring mental function. Unfortunately, they cause serious, incurable, and sometimes fatal side effects and it is impossible to predict which patients will suffer these effects. As one court concluded, "[w]e can identify few legitimate medical procedures which are more intrusive than the forcible

U.S. 1214 (1985); *Knecht v. Gillman*, 488 F.2d 1136 (8th Cir. 1973).

A national commission "noted and [could] not ignore serious deficiencies in living conditions and health care that generally prevail in prisons. Nor [could] the Commission ignore the potential for arbitrary exercise of authority by prison officials." National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *Report and Recommendations: Research Involving Prisoners*, 42 *Fed. Reg.* 3076, 3078 (1977). The Commission also recommended court review of any psychosurgery to be performed on a prisoner or involuntarily confined mental patient because "such individuals are vulnerable to coercion and . . . psychosurgery may be proposed in attempts to modify behavior for social or institutional purposes not coinciding with the patient's own interests or desires." *Report and Recommendations: Psychosurgery*, 42 *Fed. Reg.* 26318, 26330 (1977).

injection of antipsychotic medication." *In re Guardianship of Roe*, 421 N.E.2d 40, 52 (Mass. 1981).

For these and other reasons, the courts have recognized that psychotropic medications are a "high-risk treatment" that "has potentially devastating effects."³⁷ Thus "a person has a constitutionally protected interest in being left free by the state to decide for himself whether to submit to the serious and potentially harmful . . . administration of antipsychotic drugs."³⁸ Indeed, in remanding *Rogers* in light of *In re Guardianship of Roe*, this Court "assum[ed] for purposes of this discussion that involuntarily committed mental patients do retain liberty interests protected directly by the Constitution . . . and that these interests are implicated by the involuntary administration of antipsychotic drugs."³⁹ A number of courts have agreed with the conclusion of the Washington Supreme Court in this case, that "antipsychotic drug treatment is no less intrusive than ECT [electroconvulsive or electroshock therapy]," for which it is well established that an unwilling patient is entitled to a judicial hearing.⁴⁰

³⁷ *In re Guardianship of Roe*, 421 N.E.2d at 54; *Jarvis v. Levine*, 418 N.W.2d 139, 147 (Minn. 1988). Other courts have noted that these drugs "carry a significant risk," see *Mills v. Rogers*, 457 U.S. at 293 n.1 and "can inflict serious, permanent injury," see *Bee v. Greaves*, 744 F.2d at 1390. See also *Rennie v. Klein*, 653 F.2d at 843 n.8; *Davis v. Hubbard*, 506 F. Supp. at 927-929; *Opinion of the Justices*, 465 A.2d 484, 488 (N.H. 1983).

³⁸ *Rogers v. Okin*, 634 F.2d 650, 653 (1st Cir. 1980), vacated and remanded sub nom. *Mills v. Rogers*, 457 U.S. 291 (1982).

³⁹ *Mills v. Rogers*, 457 U.S. at 299 n.16. Cf. *Vitek v. Jones*, 445 U.S. at 494; *Mackey v. Procunier*, 477 F.2d at 878.

⁴⁰ Pet. App. A-6. See, e.g., *Riese v. St. Mary's Hosp. & Med. Center*, 196 Cal. App. 3d 1388, 243 Cal. Rptr. 241 (Cal. Ct. App. 1987); *People v. Medina*, 705 P.2d 961, 967 (Colo. 1985) (*en banc*); *Gundy v. Pauley*, 619 S.W.2d 730, 731-732 (Ky. 1981) (involuntary patient has right to refuse electroshock therapy "in the absence of a judicial declaration of incompetence, or an emergency"); *In re Guardianship of Roe*, 421 N.E.2d at 51-52.

Forced antipsychotic drugging involves many of the same risks which caused the Court to reject forced surgical intrusions in *Winston v. Lee*, 470 U.S. 753 (1984). There, the Court ruled, without dissent, that even a small incision to remove a bullet from a criminal suspect "implicates expectations of privacy and security of such magnitude that the intrusion may be 'unreasonable' even if likely to produce evidence of a crime." The Court stressed "the extent to which the procedure may threaten the safety or health of the individual," and "the uncertainty about the medical risks." *Id.* at 761, 764. These same factors are present here, in contrast to the "minor intrusion" to extract a blood sample which involved "virtually no risk, trauma or pain," and hence was permitted in *Schmerber v. California*, 384 U.S. 757, 771 (1966).

Despite the obvious liberty interest at issue in this case, the State persists in denying that any such interest exists. Pet. Br. at 19-20. Yet it is alone in this assertion. Its position was rejected by both the trial court and the Washington Supreme Court. As amicus United States acknowledges, "even if state law did not create a liberty interest, we believe that a prison inmate ordinarily retains a liberty interest in not receiving antipsychotic medication against his will." U.S. Br. at 15. See also APA/WPSA Br. at 16.

B. Significant Changes in Conditions of Confinement Implicate Basic Liberty Interests.

As this Court ruled in *Wolff v. McDonnell*, 418 U.S. at 571-572, a "major change in the conditions of confinement" requires that a person receive due process. Forced drugging constitutes a change in the conditions of confinement at least as significant as transfer from a prison to a psychiatric facility, which this Court found to trigger due process protection in *Vitek v. Jones*. Indeed, while transfer to a psychiatric facility may improve care, is always reversible, and normally will not extend beyond the prison term, forced medication can be worse than simple incarceration, and its effects may last a lifetime or

shorten a lifetime. As the Washington Supreme Court found, "the highly intrusive nature of anti-psychotic drug treatment warrants greater protections than . . . those necessary to protect the interests at issue in *Vitek*." Pet. App. A-18. Cf. *Jarvis v. Levine*, 418 N.W.2d 139 (Minn. 1988).

In *Vitek*, the Court cited another criterion for deciding whether due process protections are triggered: whether "the conditions or degree of confinement to which the prisoner is subjected is within the sentence imposed upon him." 445 U.S. at 493, quoting *Montanye v. Haymes*, 427 U.S. 236, 242 (1976). A prisoner's transfer from one penal institution to another is "within the sentence imposed upon him," because his sentence makes no assumption as to prison location. But this is not true of transfer to a mental hospital (*Vitek*), and it is not true of forced medication. On the contrary, as this Court noted in *Vitek*:

[I]nvoluntary commitment to a mental hospital is not within the range of conditions of confinement to which a prison sentence subjects an individual. . . . [A] criminal conviction and sentence of imprisonment extinguish an individual's right to freedom from confinement for the term of his sentence, but they do not authorize the State to classify him as mentally ill and to subject him to involuntary psychiatric treatment, without affording him additional due process protections. [445 U.S. at 493-494.]

A criminal sentence does not itself authorize forced drugging of any inmate.⁴¹ Given that an important lib-

⁴¹ In contesting this conclusion, the State relies principally on *Turner v. Safley*, 482 U.S. 78 (1987), and *Youngberg v. Romeo*, 457 U.S. 307 (1982). Both cases are readily distinguishable. In *Turner*, the Court found that it is important to inquire whether "a prison regulation that burdens fundamental rights is 'reasonably related' to legitimate penological objectives or whether it represents an 'exaggerated response' to those concerns." 482 U.S. at 87. The State mistakenly believes that this general formula means that any infringement on inmates' rights need only meet the same, low

erty interest of inmates is at stake, the real issue is what due process procedures are required to balance that interest with the legitimate interests of the State.

III. ABRIDGEMENT OF CONSTITUTIONAL RIGHTS REQUIRES DUE PROCESS.

Determining whether a change in an inmate's conditions of confinement is justified by particular behavior "becomes critical, and the minimum requirements of procedural due process appropriate for the circumstances must be observed." *Wolff v. McDonnell*, 418 U.S. at 558. Moreover, a state's "reliance on the opinion of a designated physician or psychologist for determining whether the conditions warranting a transfer exist neither removes the prisoner's interest from due process protection nor answers the question of what process is due under the Constitution."⁴²

"reasonably related" standard of justification. On the contrary, as the Court ruled in *Turner*, restrictions on less essential prisoner rights (such as exchange of mail among inmates) might be justified by a lesser "penal interest" than a restriction on core rights, such as the right to marry. Under *Turner*, a major intrusion on a person's privacy, dignity and health through forced drugging should require a very substantial justification.

Nor does *Youngberg* support the State's position. In that case, the Court ruled that a retarded person, involuntarily committed to a state institution, retains constitutional rights to reasonably safe conditions, minimally adequate training, and freedom from unreasonable bodily restraints. *Youngberg* thus confirms that confinement itself does not divest a person of rights. The State invokes *Youngberg* for the proposition that "the Constitution only requires that the courts make certain that professional judgment was in fact exercised." Pet. Br. at 19. In *Youngberg*, however, the physical restraint had no lasting effects, while antipsychotic drugs can have permanently disabling and disfiguring effects, warranting an independent judgment on their use. In addition, deference to professional judgment may have been reasonable in *Youngberg*, since the patient was retarded and functioned at the mental age of an infant. By contrast, Mr. Harper is an adult who has never been found—judicially or otherwise—incompetent to make decisions about his own medical treatment.

⁴² *Vitek v. Jones*, 445 U.S. at 491. The State's reliance on *Parham v. J.R.*, 442 U.S. 584 (1979), is misplaced because *Parham* involved

It is important to stress that the issue in this case is not whether legitimate penal interests require administering drugs to certain inmates against their will, but whether they require that it be done *without a fair hearing*. We submit there is no legitimate institutional benefit to dispensing with impartiality and basic fairness. Prisons can operate effectively if the predicate for involuntary medication is established at a hearing either at the time of incarceration, at the time of transfer to a medical facility, or as the need arises. See *Large v. Superior Court of County of Maricopa*, 714 P.2d 399 (Ariz. 1986).

Once it is established that *some* hearing is required before a competent prisoner can be drugged against his will, the correctional system has no legitimate interest in requiring that the prisoner be denied counsel, that the fact-finder be biased, or that less intrusive and less risky treatments not be considered. A sham hearing might be swifter and surer of result, but this is not a legitimate penal interest.⁴³

The State and its amici warn of dire results if prisoners are afforded a fair hearing. We will briefly answer each warning. First, fair hearing requirements will not interfere with the facility's right to treat inmates who threaten imminent violence. It is well established that even civilly committed mental patients (who *have* a right to refuse treatment) nevertheless can be medicated against their will in emergencies, *i.e.*, when necessary to

a child who could not give or withhold consent, and because in *Parham*, unlike this case, "the [appropriate] questions are essentially medical in character: whether the child is mentally or emotionally ill and whether he can benefit from the treatment." *Id.* at 609.

⁴³ See *Turner v. Safley*, 482 U.S. at 89 ("when a prison regulation impinges an inmate's constitutional rights, the regulation is valid if it is reasonably related to *legitimate* penological interests") (emphasis added).

prevent immediate harm to themselves or others.⁴⁴ The same is true in jails and prisons, and we support the principle that involuntary medication can be administered if truly necessary in order to prevent instant harm to inmates or staff. But there is no suggestion that an instant "emergency" was present here; Mr. Harper was medicated year after year, and the inadequate protections afforded him were *standard operating procedure* at the facility.

Second, the State defends its procedures on the basis of "the state's *parens patriae* interest in providing Mr. Harper with necessary mental health care." Pet. Br. at 29. However, Mr. Harper has not been found incompetent to make his *own* decisions about treatment. Unless a patient has been found incompetent, any *parens patriae* argument is limited. *Bee v. Greaves*, 744 F.2d at 1395 ("the state may not deliberately fail to provide necessary medical treatment *where it is desired by the detainee*. . . . This Constitutional requirement cannot be turned on its head to mean that if a competent individual chooses not to undertake the risk or pains of a potentially dangerous treatment the jail may force him to accept it").

Third, the State and amici APA/WSPA voice apocalyptic fears that a fair review of forced medication orders will paralyze the correctional system. On the contrary, history has shown that hearings on involuntary treatment are manageable. For example, the trial court in *Rogers v. Okin*, 634 F.2d 650 (1st Cir. 1980), enjoined forcible drugging of mental patients in non-emergencies. In the decade following that order, only about one out of ten patients appealed medication orders.⁴⁵ One study found that only 16 out of 677 hos-

⁴⁴ See, *e.g.*, *Bee v. Greaves*, 744 F.2d at 1393-96; *Rennie v. Klein*, 720 F.2d at 269; *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986); *Colorado v. Smith*, 720 P.2d 629 (Colo. Ct. App. 1986).

⁴⁵ Appelbaum, *supra* n.35, and studies cited therein.

pitalized prisoners in New York (approximately 2.5%) pursued court review of medication orders.⁴⁶

A. Constitutional Rights of Prisoners May Be Limited Only As Required For Correctional Operations.

As this Court noted in *Addington v. Texas*, 441 U.S. 418, 426 (1979), involuntary hospitalization can be justified only on two bases: police power (dangerousness) or parens patriae (for the good of the patient). If the first rationale applies, then under well-established law in the civil commitment context, a patient can be medicated without consent if he is imminently dangerous.⁴⁷ If he is *not* dangerous, so that the "good of the patient" is the only rationale for hospitalization, then before the State can make treatment decisions for the prisoner, there must first be a determination that he is incompetent to decide for himself. "Thus, medication cannot be forcibly administered solely for treatment purposes absent a finding of incompetency." *Rogers v. Okin*, 634 F.2d at 656. *Accord Jarvis v. Levine*, 418 N.W.2d at 144.

It is critical to recognize that a finding of incompetence is not implicit in a finding that a patient is mentally ill. On the contrary, all but a handful of states have statutory provisions to the effect that involuntary commitment does *not* create a presumption of incompetency.⁴⁸ In this case, Mr. Harper accepted medication voluntarily for a period of years and the State accepted his consent as

⁴⁶ L.D. Smith, "Medication Refusal and the Rehospitalized Mentally Ill Inmate," 40(5) *Hosp. & Community Psychiatry* 491 (1989).

⁴⁷ *Rennie v. Klein*, 720 F.2d at 269; *People v. Medina*, 705 P.2d at 971-975; *Riese v. St. Mary's Hosp. and Med. Center*, 243 Cal. Rptr. at 252.

⁴⁸ Brakel, *et al.*, *The Mentally Disabled and the Law*, Table 7.2 at 405-407 (3d ed. 1985). See also *Nolen v. Peterson*, No. 87-446 (Ala. Jan. 13, 1989) ("without exception, every case has repeated the proposition that absent a finding of incompetency of the patient or an emergency situation, . . . a mental patient confined involuntarily to a mental facility retains a constitutionally protected right to reject potentially harmful antipsychotic medications").

valid; only his subsequent refusal was regarded as invalid. This is contrary to established law that competency depends on the reasoning process itself, and not on which choice is made.⁴⁹

The State argues, citing *Parham*, that "[I]f the state, acting for a ward, can constitutionally make . . . an admission decision . . . certainly it is appropriate to allow the state, acting for a felon, to make the treatment decision." Pet. Br. at 30. This reasoning ignores the critical distinction between a child who is legally incompetent to give or withhold consent, and an adult felon who is presumed competent unless a court rules otherwise. Amici APA/WSPA dismiss even a competent prisoner's objection to potent drugs as a mere "preference", adding the remarkable contention that "the concept of patient preference . . . is essentially irrelevant to a due process inquiry." APA/WSPA Br. at 21. Similarly, the State argues that "for most patients, refusing psychotropic medication reflects the patient's illness rather than autonomous functioning or consistent beliefs," and it declares invalid various reasons for refusal, such as "anger" and "whim." Pet. Br. at 24.

An objection asserted year after year hardly constitutes a "whim," and forced drugging surely would provoke anger in most people. To dismiss another's reasons simply because one disagrees with them is not permissible either in health care or in law. But there is nothing in the record to suggest that Mr. Harper was *ever* incom-

⁴⁹ As former Chief Justice Burger has written, regarding Justice Brandeis' formulation of the right to be let alone:

Nothing in this utterance suggests that Justice Brandeis thought an individual possessed these rights only as to *sensible* beliefs, *valid* thoughts, *reasonable* emotions, or *well-founded* sensations. I suggest he intended to include a great many foolish, unreasonable and even absurd ideas which do not conform, such as refusing medical treatment even at great risk. [*Application of the President & Directors of Georgetown College, Inc.*, 331 F.2d 1010, 1017 (D.C. Cir.) (Burger, J., dissenting from denial of rehearing), *cert. denied*, 377 U.S. 978 (1964) (emphasis in original).]

petent to make a treatment decision during the three years he was involuntarily medicated, or that the State ever sought to have him declared incompetent. In the absence of an adjudication of incompetence, Mr. Harper has the right to refuse medication based on his own weighing of risks and benefits.⁸⁰

The State and its amici also take the position that while transfer from a prison to a mental hospital is a major change in the conditions of confinement requiring due process, the change from confinement in a special unit to forced neuroleptic medication is not such a change. This is false for the reasons described in Section II.B. Both decisions can have major consequences. In light of the risks of error, abuse, and punitive motives in the transfer of an inmate to a mental hospital,⁸¹ this Court has assured judicial review of such decisions in *Vitek v. Jones*. There should be analogous review of the decision to force an inmate to take mind-altering drugs which can cause permanent disability.

⁸⁰ "[O]nly the patient can really know the discomfort associated with side effects of particular drugs. . . . It is also difficult for any person, even a doctor, to balance for another the possibility of a cure of his schizophrenia with the risks of permanent disability in the form of tardive dyskinesia. Whether the potential benefits are worth the risks is a uniquely personal decision which, in the absence of a strong state interest, should be free from state coercion. . . . [There is also] the fact that psychiatric diagnosis and therapy is uncertain, with great divergence of opinion in any given case. . . . This also weighs toward leaving the final decision with the patient rather than deferring to doctors." *Rennie v. Klein*, 462 F. Supp. at 1145. *Accord Davis v. Hubbard*, 506 F. Supp. at 936.

⁸¹ Similar concerns about the treatment of inmates were cited recently by researchers at the University of Washington:

The behavior of mentally ill offenders promotes ambiguity for correctional staff. . . . Because infractions are taken as a primary indicator of prison adjustment, which may ultimately affect classification and release decisions, judgments about what behaviors are tolerable or are allowed as manifestations of illness are important ones. This question raises issues about the training and qualifications of correctional officers. . . . [Jemelka, Trupin, and Chiles, *supra* n.24, at 485.]

B. Involuntary Administration of Antipsychotic Drugs Is Proper Only If An Unbiased Decisionmaker Concludes That the Prisoner Is Either Dangerous or Incompetent and That Alternative Treatments Have Failed.

The State presents the Court with a 'daunting—but false—dichotomy: either prisoners have no right to meaningful review of medication decisions or prisons will be paralyzed by endless hearings and a total displacement of clinical judgment. But this Court can achieve a reasonable accommodation of both liberty and penal interests by rejecting these polar positions, in favor of a reasonable alternative.

The American Psychological Association represents psychologists who seek primarily what is best for mentally ill patients. Therefore, we reject both the unrealistic view that no patient—even if dangerous—should ever be forcibly medicated, and the paternalistic view that practitioners always know best and that patients should just do as they are told. Instead, we recognize that forcible administration of drugs sometimes is necessary, but we urge that such action be taken (except in emergencies) only if an unbiased decisionmaker finds, on the basis of due process procedures, that:

- The prisoner either is imminently dangerous or is not competent to make a treatment decision;
- Behavioral and psychological alternatives to medication have been objectively explored;
- The prisoner has a diagnosed mental illness for which the proposed drug is effective;
- Medical examinations as well as psychological, neuropsychological, and laboratory evaluations reveal no other basis for the abnormal behavior, and no condition for which the proposed drug regimen is contraindicated; and
- Forcible medication is necessary or best for the patient and others.

Standards similar to these have been adopted by many courts.⁵²

In considering what process is due, it is important to note that the procedures available for review of the medication decisions in this case were hardly as substantial as suggested by the State and its amici. Pet. Br. at 16-18; *see also* APA/WSPA Br. at 3-5. For example, the inmate had no right to counsel, although the very premise of forced medication is that the prisoner has a serious mental illness. The right to know the issues in dispute and the right to cross-examine witnesses were compromised by permitting the panel to question the facility's staff *outside* the hearing room, thus denying the prisoner an effective "opportunity to challenge the contemplated action and to understand the nature of what is happening to him."⁵³

In addition, the SOC panel was hardly unbiased, since it consisted of an administrator of the facility whose principal interest is order, and other treatment staff employed by the same facility. Although the physician proposing medication in a particular case could not be on the panel during a review of his own orders, he could participate in subsequent inquiries into whether his orders should stand or be changed. Moreover, *all* panel members were staff employees, and thus susceptible to implicit or explicit pressure for cooperation ("If you support my orders, I'll support yours"). It is instructive that month after month, year after year, this "review" panel *always* voted for more medication⁵⁴—despite the scientific literature showing that periodic respites from drugs are ad-

⁵² *See, e.g., Project Release v. Prevost*, 722 F.2d 960, 980-981 (2d Cir. 1983); *Rennie v. Klein*, 720 F.2d at 274 (Becker, J. concurring); *Rogers v. Okin*, 634 F.2d at 660; *Davis v. Hubbard*, 506 F. Supp. at 938-939; *People v. Medina*, 705 P.2d at 973.

⁵³ *Vitek v. Jones*, 445 U.S. at 496, citing *Wolff v. McDonnell*, 418 U.S. at 564.

⁵⁴ *See, e.g., Pet. App. A-3, B-5, B-6.*

visable and that prolonged use of antipsychotic drugs is proper only when the medical need is clear and compelling. *See* Section II.B, *supra*.

The record also discloses no active consideration of alternative therapies to drugs. Before a constitutional liberty interest is abrogated, reasonable alternatives must be explored. This does not necessarily mean exhaustion of every possible alternative. But it does mean that an impartial decisionmaker has reviewed the question *with* benefit of input by professionals such as psychologists who are expert in non-drug treatment alternatives, and *without* an invariable bias in favor of medication. Unfortunately, since some psychiatrists have a persistent bias in favor of drugs, often this is the only treatment option presented. The State and its amici reflect this bias by referring repeatedly to the existence of two options: drug therapy or no therapy.⁵⁵

It is unfortunate that the available alternatives to drugs often are not explored. As one District Court declared, after an exhaustive inquiry into conditions at Texas prisons:

"Treatment" there consists almost exclusively of the administration of medications, usually psychotropic drugs, to establish control over disturbed inmates. Other options, such as counseling, group therapy, individual psychotherapy, or assignment to constructive, therapeutic activities are rarely, if ever, available on the units. Essentially, an inmate with a mental disorder is ignored by unit officers until his condition becomes serious. When this occurs, he is medicated excessively. . . . With constructive psy-

⁵⁵ *See, e.g.,* the statement of amici APA/WSPA that there is an "absence in the majority of cases of *any* feasible therapeutic alternatives." (APA/WSPA Br. at 14.) (emphasis in original). They also stress that Mr. Harper deteriorated without medication—but of course he received no alternative therapy. Indeed, they refer to the prisoner who is not on drugs as "untreated." *Id.* at 20. *See also* Pet. Br. at 31; WCMHC Br. at 13.

chotherapy virtually non-existent on the units, a large number of inmates resort to self-mutilations and suicide attempts, as dramatic cries for help.⁵⁶

Ignoring the alternatives is particularly tragic because "the therapeutic value of antipsychotic medication depends upon the existence of a trusting relationship," *People v. Medina*, 705 P.2d at 970, and "if the patient is unwilling to accept it, the positive effects are greatly lessened." *Rennie v. Klein*, 462 F. Supp. at 1141. *Accord Davis v. Hubbard*, 506 F. Supp. at 936. Moreover, behavioral and psychological therapies often are effective in treating assaultive behavior and psychosis.⁵⁷ To be optimally effective, the choice of drug therapy should be informed by neuropsychological and psychological assessments, and often must be accompanied by behavioral and other therapy.⁵⁸

Because the State and its employees persist in ignoring the scientific risks of antipsychotic drugs, and in viewing them as the only treatment for behavioral problems, their demands for forcible medication should be subject to review by either a court or an unbiased administrative

⁵⁶ *Ruiz v. Estelle*, 503 F. Supp. 1265, 1332, 1334 (S.D. Tex. 1980), *aff'd in part and vacated in part, modified* 679 F.2d 1115 (5th Cir. 1982), *cert. denied*, 460 U.S. 1042 (1983).

⁵⁷ See, e.g., Glynn, *et al.*, "Compliance with Less Restrictive Aggression-Control Procedures," 40(1) *Hosp. and Community Psychiatry* 82 (1989); Karon & VandenBos, *Psychotherapy of Schizophrenia: The Treatment of Choice* (1981); Paul and Lentz, *Psychosocial Treatment of Chronic Mental Patients: Milieu vs. Social Learning Programs* (1977); Karon & VandenBos, "Cost/Benefit Analysis for Schizophrenia Patients Treated by Psychologists, Psychiatric Psychotherapists, and Medication without Psychotherapy," 7 *Prof. Psychology* 107 (1976).

⁵⁸ "[I]t becomes increasingly clear that both modalities will continue to be necessary: psychotropic drugs to reduce vulnerability and psychological treatments to enhance coping skills. . . . Biological approaches should no longer be competitive but, rather, cooperative in the interest of the mentally ill." Meltzer and Lipton, "Introduction" in *Psychopharmacology: The Third Generation of Progress* (Meltzer, ed. 1987) at xii.

body. This body should include professionals who are not employees of the prison, and who represent a variety of disciplines (e.g., psychologists, psychiatrists, psychiatric social workers, internists and others) whose views concerning antipsychotic medication may balance one another.

CONCLUSION

Except in an emergency, before a prisoner is forced to take potentially disabling antipsychotic drugs, he should receive a fair hearing before an unbiased, independent body, to determine that:

- The prisoner either is imminently dangerous or is not competent to decide about his own treatment;
- Medical, psychological, neuropsychological and laboratory evaluations reveal no other cause of the abnormal behavior and confirm that the prisoner has no condition for which the proposed drug is contraindicated;
- The proposed drug is effective for the prisoner's diagnosed mental illness;
- Alternative approaches (behavioral and psychological as well as drugs) have been objectively explored; and
- Forcible medication is necessary or best for the prisoner and others.

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BRIEF

(11)
No. 88-599

IN THE

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OF THE DISABLED
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AS AMICI CURIAE**

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INTEREST OF AMICI CURIAE

Amici curiae are organizations which provide legal services to institutionalized mentally ill persons in Massachusetts. The Mental Health Legal Advisors Committee (MHLAC) is a state agency within the Massachusetts Supreme Judicial Court and operates pursuant to statutory authorization. Mass. Gen. Laws Ann. (West 1989) ch. 221 34. MHLAC, among its duties, has the responsibility to insure that residents of the state's mental

hospitals are afforded the opportunity to fully exercise their rights. To this end, MHLAC trains and certifies the competency of all attorneys who are appointed to represent mentally ill individuals in judicial proceedings involving treatment with antipsychotic drugs and civil commitment. MHLAC filed a brief as amicus curiae with this Court in *Mills v. Rogers*, 457 U.S. 291 (1982), which raised similar issues to those presented here.

The Coalition for the Legal Rights of the Disabled is a coalition of over forty agencies and numerous individuals which advocate to insure and enhance the rights of people with disabilities in Massachusetts and has filed amicus briefs in cases involving the right to refuse treatment in the Massachusetts Supreme Judicial Court.

The Center for Public Representation is a public interest law firm which provides legal services to institutionalized people with mental illness. Among its other functions the Center is the designated mental health protection and advocacy system for Massachusetts pursuant to the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (P.L.99-319). Center staff frequently represent individuals in cases involving forced treatment with antipsychotic drugs. Staff of the Center have filed briefs in this court as counsel for other amici in *Halderman v. Pennhurst*, 451 U.S. 1 (1987) and *City of Cleburne, Tex. v. Cleburne Living Center*, 473 U.S. 432 (1985).

Amici, therefore, are thoroughly familiar with the implementation of the procedures by which patients in Massachusetts may be forced to undergo treatment with antipsychotic medication against their will. Permission to file this brief has been obtained from the parties.

STATEMENT OF THE CASE

Amici adopt and incorporate by reference the statement of the facts of this case contained in the opinion below.

Harper v. Washington, 110 Wash. 2d 873, 759 P.2d 358, 360-61 (1988). (Appendix A of petition for certiorari at pp. A-2 -A-4.)

SUMMARY OF ARGUMENT

This case requires the Court to decide whether individuals with mental illness are entitled to a judicial hearing prior to treatment with antipsychotic medication against their will and without their informed consent. As the result of a series of federal and state court decisions, Massachusetts has recognized a constitutional and common law right to refuse treatment and has mandated a judicial process for deciding when, if at all, individuals may be medicated against their will.

In this brief, amici show that the judicial process has functioned effectively and efficiently in applying constitutional rights, and appropriately balancing individual and state interests, and that the disastrous consequences that were predicted to result from this judicial model have clearly not occurred.

Based on the Massachusetts experience, amici argue that the procedures established by the Washington Supreme Court comport with constitutional requirements and that a judicial model of decision making will protect the rights of people with mental illness without causing any undue burden on the state.

ARGUMENT

I. THE PROCEDURES MANDATED BY THE WASHINGTON SUPREME COURT, LIKE THOSE ADOPTED BY MANY OTHER STATES, ARE NECESSARY TO INSURE THAT PEOPLE WITH MENTAL ILLNESS ARE AFFORDED THE OPPORTUNITY TO EXERCISE THEIR CONSTITUTIONAL RIGHT TO REFUSE TREATMENT.

In 1960, Justice Schroeder of the Kansas Supreme Court stated a simple principle which is fundamental to an understanding of this case. He wrote:

Anglo-American law starts with the premise of thoroughgoing self-determination. It follows that each man is considered to be master of his own body, and he may, if he is of sound mind, expressly prohibit the performance of life-saving surgery or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.

Natanson v. Kline, 350 P.2d 1093, 1104 (Kan. 1960). The "premise of thoroughgoing self-determination" applies to a person with a mental illness as surely as it does to a person with a physical illness.¹

¹Any restrictive application of this principle which distinguishes between citizens solely on the basis of the nature of their disability would, absent a compelling reason to do so, raise serious questions under the Equal Protection Clause of the Fourteenth Amendment as well as under various nondiscrimination statutes. See, e.g., 29 U.S.C. §§ 501-504.

A. Virtually Every Court That Has Considered The Issue Has Found That The United States Constitution Accords An Individual The Right To Be Free From Forced Psychiatric Medication.

Whether relying on First or Fourteenth Amendment rationales, virtually every court—state and federal alike—that has addressed the issue of forced treatment with antipsychotic drugs² has found that fundamental constitutional rights are involved. Courts have recognized that interests in (1) personal bodily integrity, (2) unimpaired mental pro-

²Antipsychotic drugs are used for the treatment of psychotic disorders. Among the most common antipsychotics are Thorazine (chlorpromazine), Stelazine (trifluoperazine) Trilafon (perphenazine), Mellaril (thioridazine), Prolixin (fluphenazine), Navane (thiothixene) and Haldol (haloperidol). The mechanism of action of the antipsychotics is not completely understood. At the cellular level, it is believed that the drugs inhibit transmissions of nerve impulses in the central nervous system. This is apparently accomplished by the blocking of the action of dopamine, a neurotransmitter. Waldinger, "Somatic Therapies," in *Psychiatry for Medical Students* (1984). Whatever the mechanism of action, the antipsychotics do not cure mental illness, but merely repress its overt manifestations. In addition, not all persons with psychotic disorders benefit from antipsychotic medication and there is evidence that their effectiveness depends on a variety of factors including the patient's attitudes about treatment and those who are providing it. Cole, "Patients' Rights versus Doctors' Rights: Which Should Take Precedence?," in *Refusing Treatment in Mental Institutions—Values in Conflict*, 56, 57 (A.E. Doudera & J.P. Swazey, eds., 1982).

Antipsychotics also can have unwanted side-effects. These include akathisia (motor restlessness and the inability to sit still), akinesia (physical immobility and lack of spontaneity), dystonia (spasmodic muscle reaction), pseudo-parkinsonian symptoms (mask-like face, rigidity), neuroleptic malignant syndrome (rigidity, dance-like movements and alterations in consciousness which may be fatal) and tardive dyskinesia (involuntary motor movements). "While in mild cases [tardive dyskinesia] can simply be a source of embarrassment, it can be physically and psychologically disabling." *Rogers v. Okin*, 478 F. Supp. 1342, 1360 (D. Mass 1979).

cesses to allow free thought and communication and (3) the freedom to make decisions about one's own mind and body are implicated when a state seeks to medicate a person with antipsychotic drugs without consent. See, for example, *Bee v. Greaves*, 744 F.2d 1387, 1393 (10th Cir. 1984), cert. denied, 105 S. Ct. 1187 (1985)(right to privacy); *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983)(right to privacy); *Rogers v. Okin*, 634 F.2d 650, 653 (1st Cir. 1980)("[A] person has a constitutionally protected interest in being left free by the state to decide for himself whether to submit to the serious and potentially harmful medical treatment that is represented by the administration of antipsychotic drugs."); *Rogers v. Commissioner of Department of Mental Health*, 390 Mass. 489, 458 N.E.2d 308, 314 (1983)("[t]he right to forgo treatment has constitutional and common law origins."); *Davis v. Hubbard*, 506 F. Supp. 915 (N.D. Ohio. 1980)(Fourteenth Amendment liberty interest); *Large v. Superior Court*, 148 Ariz. 229, 714 P.2d 399 (1986)(due process); and *Scott v. Plante*, 532 F.2d 939, 946 (3d Cir. 1976)(due process).³

While not every one of these cases has mandated judicial decision making as the process to override a patient's refusal of treatment, most have. Although the precise procedures and the actual legal standards vary, many courts have required a judicial hearing to determine the competence of a patient and to make treatment decision prior to the non-emergency administration of antipsychotic medication against a patient's will. See, e.g., *Rogers v. Commissioner of Department of Mental Health*, *supra*; *In re Orr*, 176 Ill. App. 3d 498, 531

³Although it did not reach the underlying question, the opinion of this Court in *Mills v. Rogers* does contain some discussion of the right to refuse treatment. For example, the Court notes that the parties to the appeal all agreed that "the Constitution recognizes a liberty interest in avoiding the unwanted administration of antipsychotic drugs." 457 U.S. 291, 299 (1982). Also, the Court "assume[d] that involuntarily committed mental patients do retain liberty interests protected by the Constitution and that these interests are implicated by the involuntary administration of antipsychotic drugs." *Id.*, 457 U.S. at 299 n.16.

N.E.2d 64 (1988); *Jarvis v. Levine*, 418 N.W.2d 139 (Minn. 1988); *In re Bryant*, 542 A.2d 1216 (D.C. 1988); *State ex rel. Jones v. Gerhardstein*, 141 Wis.2d 710, 416 N.W.2d 883 (Wis. 1987); *In re Mental Commitment of M.P.*, 510 N.E.2d 645 (Ind. 1987); *Reise v. St. Mary's Hosp. & Medical Ctr.*, 196 Cal. App.3d 1388, 243 Cal. Rptr. 241 (1987); *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986); *People v. Medina*, 705 P.2d 961 (Colo. 1985); *Opinion of the Justices*, 123 N.H. 554, 465 A.2d 484 (1983).

In *Harper v. Washington*, *supra*, the Washington Supreme Court, following the lead of the Massachusetts *Rogers* case and of the decisions in other states, properly required a judicial procedure before a person may be involuntarily treated with antipsychotic medication.

B. *The Liberty Interests Implicated When An Individual Is Treated With Antipsychotic Drugs Against His Will Require A Judicial Model Of Decision Making.*

Courts and commentators considering the nature of the principle of self-determination in medical decision making usually focus on two aspects of this right. They are, first, the fundamental dignity and self-esteem attendant to the control of one's own life and, second, the uniquely subjective and individual nature of the process of gaining information, weighing the potential risks and benefits and reaching a decision. See, e.g., *Cobbs v. Grant*, 8 Cal.3d 229, 502 P.2d 1110 (1982); J. Katz, *The Silent World of Doctor and Patient* (1984). Therefore, while most people follow the advice of their physicians and act in a reasonable manner to further their own best interests, an essential feature of the principle of self-determination is the right to make decisions which others may think unwise or wrong.

Thus, a determination of how best to exercise this liberty interest for people who are unable to exercise it themselves must take into account the necessarily subjective

nature of the decision making process. There are several important considerations which mandate that such subjective decisions be made within the framework of a judicial process.

First, decisions to authorize treatment with antipsychotic medications are, at least for constitutional purposes, indistinguishable from other medical situations which routinely come before courts. For example, the judicial model is commonly invoked in attempts to override a competent person's refusal to consent to medical care. See, e.g., *In re Application of the President and Directors of Georgetown College, Inc.*, 331 F.2d 1010 (D.C. Cir. 1964)(ordering a blood transfusion over the objection of a Jehovah's Witness adult) and *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978)(recognizing the right of a competent adult to refuse an amputation).

Second, judicial decisions to consent to life-saving or life-prolonging care—or to allow withdrawal of such treatment—are similarly required for persons incapable of consenting to medical or psychiatric treatment. See, e.g., *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977)(court approval necessary to authorize chemotherapy treatment for incompetent person with leukemia); *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334 (Del. 1980)(decision to withdraw life-sustaining medical care from comatose patient must be made by a court), and, *Price v. Shepard*, 307 Minn. 250, 239 N.W.2d 905 (1976) (court authority necessary to treat incompetent person with electroshock). There is no justifiable reason to consider treatment with antipsychotic medication any differently than other medical or psychiatric treatment.

More generally, courts have always been the appropriate forums for determining whether, and to what extent, decisions to curtail fundamental rights are made. The most obvious example in the context of this case is the law and process of guardianship. Jurisdiction over the person and

property of incompetent people has been assumed by courts of equity since colonial times. S. Brakel, J. Perry, B. Weiner, *The Mentally Disabled and the Law* 369 (1985). Because such jurisdiction has often included review and approval of medical procedures, courts are particularly adept at making decisions for people who cannot decide for themselves.

Courts are also the most appropriate forum in which to weigh conflicting individual and institutional interests. Decisions about competency and treatment require that a delicate balance be struck among the individual's interest in personal freedom, society's interest in protecting and caring for those who cannot care for themselves, and whatever other interests may arise in a particular case, including those of family members, state agencies, or related third parties. Unlike all the other participants in treatment disputes (including the members of the administrative panel under the previous Washington procedure), judges are dispassionate and neutral observers uniquely qualified to impartially weigh all of the factors—medical and personal, objective and subjective—which are pertinent to a patient's decision with respect to both the need for and desirability of medical treatment.

In addition to their obvious impartiality, judges are by education, training and experience better able to weigh the liberty interests and entitlements of the patients and, unlike medical professionals, are not ethically committed to a particular outcome, that is, to treatment. Judges also have the capacity to ensure, through the patient's representative, that the patient's interests are adequately articulated. Writing in support of the adversary judicial decision making process, one state court judge has characterized his role as the "judicial version of [the] respectful conversations with a physician" which is advocated by Professor Jay Katz in his important work *The Silent World of Doctor and Patient* (1984). Dunphy & Cross, "Medical Decision making for Incompetent Persons: The Massachusetts Substituted Judgment Model," 9 W. New Eng. L. Rev. 153, 162 (1987).

Similarly, where it is asserted that there exist compelling state interests sufficient to override a patient's or a substitute decision-maker's decision, judges, rather than medical or administrative personnel, are better able to make such determinations.⁴ *Id.*, at 157.

Petitioner's assertion that the non-judicial procedure established in Special Offender Center Policy (SOCP) 600.30 provides sufficient due process protection is based upon a misperception of the liberty interest involved when a person is forcibly treated with antipsychotic medication.

The issue is not whether such treatment is medically necessary or in the patient's "best interest." Rather, the issue is how and by whom a patient's right to decide whether to accept or refuse to accept treatment may best be exercised and protected.⁵

As Petitioner notes, this Court has not had occasion to consider this precise issue. Petitioner then discusses three cases decided by this Court which, it is asserted, presented issues which are sufficiently analogous to that of the instant

⁴For further analyses of the distinctions between the judicial and medical decision-making models, see, e.g., Baron, *Medical Paternalism and the Rule of Law: A Reply to Dr. Reiman*, 4 Am.J.L. & Med. 337, 346 (1979) and Hacker, *Medicating Committed Psychiatric Patients Over Their Objections*, 14 Rutgers L.J. 685, 699 (1983).

⁵See, e.g., *Cobbs v. Grant*, *supra*:

A medical doctor being the expert appreciates the risks inherent in the procedure he is prescribing, the risks of a decision not to undergo a treatment, and the probability of a successful outcome of the treatment. But once this information has been disclosed, that aspect of doctors' expert function has been performed. The weighing of those risks against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a non-medical judgment reserved for the patient alone.

8 Cal. 3d at 243.

case to provide guidance in its resolution.⁶ As in the instant case, the *Parham*, *Vitek* and *Youngberg* cases considered whether reliance by states upon medical, rather than judicial, substitute decision-makers accorded certain patients sufficient due process protection. However, the type of decisions at issue in those three cases was fundamentally different from that now presented.

The authority to make decisions concerning the acceptance or refusal of prescribed medical treatment has always, absent an emergency, been vested in an adult patient. Children, however have not been accorded such authority. Similarly, persons subject to the exercise of a state's "police power" traditionally have not been afforded the opportunity to choose the method by which they are restrained or the setting in which they are detained. Reliance upon professional medical judgment may be sufficient in some situations, such as, treatment for children with parental consent (*Parham*), transfer to a mental facility due to dangerousness (*Vitek*) or the use of physical restraint (*Youngberg*). But, where, as here, the right at issue is that of a patient posing no threat of imminent harm to himself or others to choose what, if any, medical treatment is to be administered, judicial abdication to doctors is neither warranted nor efficient.

II. MASSACHUSETTS HAS ADOPTED A JUDICIAL MODEL FOR DETERMINING WHETHER AND WHEN TO ADMINISTER ANTIPSYCHOTIC MEDICATION WHICH IS EFFICIENT, EFFECTIVE AND APPROPRIATE.

Massachusetts and other states have recognized these distinctions and have successfully adopted a judicial model of decision making. The petitioner's *amici* cite to the Mass-

⁶Brief of Petitioners, at 9-11. The cases discussed are *Parham v. J.R.*, 442 U.S. 584 (1979), *Vitek v. Jones*, 445 U.S. 480 (1980) and *Youngberg v. Romeo*, 457 U.S. 307 (1982).

achusetts experience with some disapproval, see, e.g., *Brief Amici Curiae of Washington Community Mental Health Council et al.* pp. 19-21; *Brief for American Psychiatric Association et al. as Amici Curiae*, pp. 26-28. An understanding of the Massachusetts litigation and its impact on people with mental illness, on the state's mental health system and on the state's courts provide a more accurate and illuminating perspective on the actual experience of a judicial decision making model.

Massachusetts has an extensive body of case and statutory law regarding the rights of patients to self determination in medical decision making. The case which set the standard was *Superintendent of Belchertown State School v. Saikewicz*, *supra*, in which case the Supreme Judicial Court affirmed a trial court's denial of authority to treat an incompetent mentally retarded man with chemotherapy for his leukemia. The court held that all people—regardless of their competency—have constitutional rights which include the right to be free of "unwanted infringement of bodily integrity," *Id.*, 370 N.E.2d at 424, and that the right may be overcome only in light of a compelling state interest. *Id.*, 370 N.E.2d at 424-27. Furthermore, the court held that a judicial adjudication of incompetence must precede any determination to override a patient's right to make his or her own treatment decisions. If a court determines a person to be incompetent it must then make a substituted judgment determination "the goal [of which] is to determine with as much accuracy as possible the wants and needs of the individual involved." *Id.*, 370 N.E.2d at 430 (footnote omitted). If the individual's substituted judgment is to refuse the treatment offered, that refusal must be honored except in the face of a compelling countervailing state interest.

The Massachusetts court specifically rejected the argument that treatment decisions are inappropriate for judicial decision making. Rather, the court held that such "difficult and awesome question[s]" seem to "require the process of detached but passionate investigation and decision that forms

the ideal on which the judicial branch of government was created." *Id.*, 370 N.E.2d at 435.

The *Saikewicz* case was only the first in a line of Massachusetts decisions which establish that at least in some areas of medical decision making, individuals have the right to a judicial determination of competency and, if incompetent, to a determination of their substituted judgment before they may be treated against their will. See, e.g., *Custody of a Minor*, 385 Mass. 697, 434 N.E.2d 601 (1982) (chemotherapy for a child with leukemia); *Matter of Spring*, 380 Mass. 697, 405 N.E.2d 115 (1980) (ward's substituted judgment is to refuse kidney dialysis); *Matter of Moe*, 385 Mass. 697, 432 N.E.2d 712 (1982) (guardian must obtain specific authority of court applying substituted judgment standard before an incompetent woman with mental retardation may be sterilized); *In re Richard Roe III*, 383 Mass. 415, 421 N.E.2d 40 (1981) (noninstitutionalized mentally incompetent patient has right to judicial hearing and determination of substituted judgment before he may be treated against his will with antipsychotic medications); *Brophy v. New England Sinai Medical Center, Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986) (substituted judgment of a person in a "persistent vegetative state" is to discontinue receiving nutrition and hydration through surgically inserted gastrostomy tube).

In the *Roe* case the Massachusetts court extended its analysis in *Saikewicz* to an individual with mental illness whose parents sought to administer antipsychotic medication which *Roe's* doctor recommended but which *Roe* refused. *In re Richard Roe III*, 421 N.E.2d at 43-44. The Supreme Judicial Court began its analysis in *Roe* by reaffirming its "preference for judicial resolution of certain legal issues arising from proposed extraordinary medical treatment." *Id.*, 421 N.E.2d at 51.⁷ Addressing whether the treatment proposed for Mr. *Roe*

⁷The court stated that it was "mindful" of this Court's warning in *Parham v. J.R.*, *supra*, n.5, that the judicial model for fact-finding sometimes "can turn rational decision-making into a unmanageable enter-

was of the nature requiring such judicial resolution, the court recognized that "few legitimate medical procedures [] are more intrusive than the forcible injection of antipsychotic medication." *Id.*, 421 N.E. 2d at 52. The court held that Mr. Roe's circumstances were not such that immediate action was necessary and noted that in any case, "expedited decision[s] can be obtained when appropriate" in Massachusetts courts. *Id.*, 421 N.E.2d at 55 quoting *Matter of Spring*, 405 N.E.2d at 124. Finally, the court determined that each of the other individuals involved in the case had some likelihood of a conflicting interest. Therefore, the court concluded a judicial model of decision making was warranted since it was "convinced that the regularity of the procedure—guaranteed by a judicial determination—will insure the objectivity which other processes might lack." *Id.*

The *Roe* decision was specifically limited to noninstitutionalized people with mental illness. But in *Rogers v. Commissioner of the Department of Mental Health*, *supra*, the Supreme Judicial Court extended the *Roe* case to institutionalized persons as well. Again it concluded that, absent an "emergency," a judicial determination of incompetence must precede any effort to override a mental patient's objection to treatment with antipsychotic drugs. *Id.*, 458 N.E.2d at 314. The court also concluded that the right to make treatment decisions derives from individuals' rights to manage their own affairs, rights which may be limited only after a judicial determination of incompetency. *Id.*, 458 N.E.2d at 314. The court specifically rejected the argument that doctors should make treatment decisions for patients whether competent or not, holding instead that judicial process

prise." *Id.*, at 608 n.16. Nevertheless, given the nature of the right and the nature of the proposed treatment the court again opted for a judicial resolution. *In re Richard Roe III*, 421 N.E. 2d at 51.

was necessary to override treatment refusals of incompetent patients.⁸ *Id.*, 458 N.E.2d at 315.

It stated that "no medical expertise is required [for making the substituted judgment determination], although medical advice and opinion is to be used for the same purposes and sought to the same extent that the individual would, if he were competent." *Id.*, quoting *Roe*, 421 N.E.2d at 52. The court expressed particular concern with the inherent conflicts of interest since doctors must maintain order⁹ in the hospital as well as treat patients.¹⁰ *Id.*, 458 N.E.2d at 317-18 & n.14.

The Supreme Judicial Court's holding in *Rogers* was accepted by the First Circuit as satisfying the substantive and procedural protections of the Fourteenth Amendment. *Rogers v. Okin*, 738 F.2d at 6.

⁸In an amicus curiae brief in *Rogers* the American Psychiatric Association (APA) proposed that Massachusetts adopt a "medical model" of decision-making suggesting that such a model would protect the incompetent person's civil rights, would provide the institution with a qualified medical opinion, and would provide for flexibility in hospital administration while avoiding the adversarial quality of judicial proceedings. *Id.*, 458 N.E.2d at 317. The Supreme Judicial Court specifically rejected the APA's "medical model."

⁹The Supreme Judicial Court also rejected the defendants' arguments that if limitations were placed on their authority to medicate patients, "hospital administration [would] become[] more difficult, lengths of stay [would] increase, fewer patients [would be] treated, staff turnover [would] increase[], and new personnel [would] become more difficult to attract." *Id.*, 458 N.E.2d at 319-20. The court found that, if true — which they are not, *see* section III, *infra* — they were outweighed by the patients' right to make treatment decisions. *Id.*, 458 N.E.2d at 320.

¹⁰However, it did recognize that in rare circumstances a patient may be treated against his or her will to prevent the "immediate, substantial and irreversible deterioration of a serious mental illness." *Id.*, at 322.

III. IN ADDITION TO PROTECTING THE RIGHTS OF PEOPLE WITH MENTAL ILLNESS, THE ROGERS DECISIONS HAVE HAD A POSITIVE IMPACT ON THE MENTAL HEALTH SYSTEM IN MASSACHUSETTS.

The impact of the *Rogers* decisions on the mental health system and on people with mental illness in particular has been salutary. The rules of law and the procedures established by the courts have insured that individual rights are protected without seriously burdening the operation of the mental health system.

The recognition of the individual's role in the decision making process, whether directly in the case of a competent person or indirectly by means of a substitute decision-maker for an incompetent person, has had a substantially positive effect upon the patient/clinician relationship.¹¹ In fact, few patients refuse treatment for any prolonged period.¹² Only 2% did so over a two-year period during which the district court's initial restraining order in *Rogers* was in effect.¹³ To whatever extent that physicians are required to devote increased time to the development of comprehensive and particularized treatment plans and to talking with and counselling clients in legitimate efforts to obtain informed consent, this can only be seen as a substantial benefit in terms of the services to patients. In fact, there is evidence that a number of individuals have been appropriately withdrawn from medication because, upon closer scrutiny, the doctors did not believe they could sustain present sufficient

¹¹See, e.g., Cole, *supra* no.2 at 58.

¹²See, Rogers and Centifanti, "Madness, Myths, and Reality: Response to Roberta Rose," 14 *Schizophrenia Bull.* 7 (1988).

¹³*Rogers v. Okin*, 478 F. Supp. at 1369. Indeed, the court found, at 1370, that the great majority of patients did not decline their medication during the pendency of the TRO. Most of those who did changed their minds within a few days.

proof of need.¹⁴ One reason for the high court success rate cited by Massachusetts mental health officials is that the legal process weeds out those cases in which incompetency or the need for medication cannot be established.

Nevertheless, the response to *Rogers* by the medical community has been predictable. The spectre of patients languishing in mental health facilities, their conditions rapidly deteriorating, while advocates were off in court espousing legal concepts of liberty and privacy to judges who had no understanding of the "true" needs of the mentally ill, has been raised repeatedly.¹⁵

But, predictions that treatment refusers would remain hospitalized for longer periods than similarly situated patients who accept treatment have not been substantiated.¹⁶ Where it was predicted that the court's order would create an adversarial relationship between staff and patients, thereby making treatment impossible, such an effect has not been noted.¹⁷ Concerns have also been raised as to the amount of time physicians would have to devote to compliance with

¹⁴Schwartz, "Equal Protection in Medication Decisions: Informed Consent, Not Just the Right to Refuse," in ABA, *The Right to Refuse Antipsychotic Medication*, 74 (1986).

¹⁵See, e.g., Gutheil and Appelbaum, "The Patient Always Pays: Some Reflections on the Boston State Case and the Right to Rot," 5 *Man and Medicine* 3 (1980). These alarming statements closely parallel those of law enforcement officials in response to this court's opinion in *Miranda v. Arizona*, 384 U.S. 436 (1966). Such concerns may be respected, but cannot be controlling.

¹⁶See Williams, et al. "Drug Treatment Refusal and Length of Hospitalization of Insanity Acquittes" 16 *Bull. Am. Acad. Psychiatry & Law* 279 (A88) (refusal of treatment had no measurable effect on length of hospital stay).

¹⁷Cole, *supra*, n.2 at 66.

court procedures,¹⁸ time which could have been better spent in providing treatment. *Amici* believe that such activity is neither detrimental to patients nor excessive. Virtually all *Rogers*-type cases in Massachusetts are heard at the various mental health facilities. Therefore, the time spent away from the facilities by staff is relatively small. Furthermore, the time actually spent by clinical staff in preparing necessary documents for submission to the courts has also been minimized by the development of standardized forms by the legal staff of the Department of Mental Health and by detailed standard procedures developed by the courts.¹⁹

Many clinicians feared that the delay in treating patients pending judicial authorization would result in an increase in accidents and injuries to patients and staff of mental health facilities. A review of Massachusetts mental health department data by *amici* reveal that this has not been the case. Nor has there been an increase in the use of other forms of restraint to control violent and destructive behavior.²⁰

¹⁸The procedure established in SOCP 600.30 requires that a psychiatrist, psychologist and an administrator review the need for treatment with antipsychotic medication. It would appear that under this procedure, substantially more clinical and administrative time would be devoted to the substitute decision-making process than that required as a result of the *Rogers* decision. Thus, the concerns raised in this paragraph are not pertinent to the instant case.

¹⁹See, Dunphy & Cross, "Medical Guardianships for Mentally Disabled Persons: Probate Practice and Procedure," 2 Mass. Family L.J. 17 (1984); Ginsburg, "Guardianships - Due Process," 1 Mass. Family L.J. 56 (1983).

²⁰Massachusetts Department of Mental Health Monthly Facility Monitoring Reports (1983-1985); Schwartz, *supra*, n.14, 77-78.

CONCLUSION

Therefore, the use of judicial decision making to determine when, if at all, to medicate an individual with antipsychotic drugs against his will, has proven an efficient and effective process in Massachusetts. For the reasons set forth above, *amici* urge this Court to affirm the judgment of the Washington Supreme Court.

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AMICUS CURIAE

BRIEF

JUN 30 1988

JOSEPH F. SPANIO, JR.
CLERK

No. 88-599

In the Supreme Court of the
United States

October Term, 1988

State of Washington, et al.,

Petitioner,

v.

Walter Harper,

Respondent.

ON WRIT OF CERTIORARI TO
THE SUPREME COURT OF THE STATE
OF WASHINGTON

**BRIEF OF THE NATIONAL ASSOCIATION OF
PROTECTION AND ADVOCACY SYSTEMS,
NATIONAL ASSOCIATION FOR RIGHTS
PROTECTION AND ADVOCACY, PROTECTION
AND ADVOCACY, INC. AND MICHIGAN
PROTECTION AND ADVOCACY INC.,
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QUESTIONS PRESENTED

- (1) Is incarcerated felon constitutionally entitled to judicial hearing and attendant adversarial procedural protection prior to involuntary administration of medically prescribed anti-psychotic medication?
- (2) If incarcerated felon possess constitutionally protected liberty interest in refusing medically prescribed anti-psychotic medicine, must state prove compelling interest to administer anti-psychotic medication or instead does "reasonable relation" standard of *Turner v. Safley*, 55 LW 4719 (U.S. Sup.Ct. 1987), control?

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No. 88-599

**In the Supreme Court of the
United States**

October Term, 1988

State of Washington, et al.,

Petitioner,

v.

Walter Harper,

Respondent.

**BRIEF OF THE NATIONAL ASSOCIATION OF
PROTECTION AND ADVOCACY SYSTEMS,
NATIONAL ASSOCIATION FOR RIGHTS
PROTECTION AND ADVOCACY, PROTECTION
AND ADVOCACY, INC. AND MICHIGAN
PROTECTION AND ADVOCACY INC.,
SUPPORTING RESPONDENT**

INTEREST OF AMICI CURIAE

The National Association of Protection and Advocacy Systems represents agencies established pursuant to Section 113 of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §6042, and the Protection and Advocacy for Mentally Ill Individuals Act of 1986, 42 U.S.C. §§10801 *et seq.* These agencies have the statutory mandate to protect and advocate the

rights of developmentally disabled persons and persons identified as mentally ill. As part of this mandate Protection and Advocacy agencies in each state represent mentally ill individuals who are involuntarily subjected to neuroleptic drugs.

The National Association for Rights Protection and Advocacy (NARPA) is a national organization of advocates, consumers of mental health services, family members and mental health professionals committed to enhancing the rights of people labelled mentally disabled. One of NARPA's priority concerns is the right of hospitalized patients to refuse neuroleptic drugs.

Protection and Advocacy Inc., is the agency designated in California pursuant to the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §6042, and the Protection and Advocacy for Mentally Ill Individuals Act of 1986, 42 U.S.C. §§10801 *et seq.*, to represent developmentally disabled persons and persons identified as mentally ill. Protection and Advocacy, Inc. represents persons subjected to neuroleptic drugs and recently litigated a case before the California Court of Appeal which, similar to the holding of the Washington Supreme Court, established the right of patients to refuse unwanted neuroleptic drugs. The issue now before this Court is also of interest to this agency because California courts have similarly held that prisoners, like Respondent Harper, have rights to judicial review prior to long-term forced drugging.

Michigan Protection and Advocacy Inc. (Michigan P&A) is the agency designated in Michigan pursuant to the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. § 6001 *et seq.*, to advocate for and protect the rights of persons with developmental disabilities and persons labeled mentally ill. Under its

federal mandate, Michigan P&A represents persons who want to refuse neuroleptic drugs. The right to accept or reject treatment in psychiatric hospitals is a high priority of the agency, and during the first six months of fiscal year 1989, advocacy on behalf of persons refusing medication made up a significant portion of its caseload.

The parties have consented to the filing of this brief. Their letters of consent have been submitted to the Clerk of the Court.

SUMMARY OF ARGUMENT

This case raises the question of whether a legally competent person can refuse powerful neuroleptic drugs when there is no emergency situation threatening the physical safety of either the inmate or others. The Supreme Court of Washington held that the highly intrusive nature of these drugs requires that the decision regarding this medical intervention, absent a judicial determination of incompetency, must be left to the person who will suffer the drug's consequences.

The effects of forced drugging on the patient are not limited to the long established neurological side-effects. It is becoming apparent that neuroleptic drugs can be totally debilitating and even lethal. An underrecognized and underdiagnosed result of these drugs is Neuroleptic Malignant Syndrome, which is now believed to cause thousands of deaths yearly. This explosively developing disorder may cause the patient to suffer from muscle rigidity, hyperthermia, and renal failure, all of which may result in the patient's death.

Just as the psychiatric community initially denied the existence of Tardive Dyskinesia, a disabling neurological disorder affecting up to 50% of patients taking neuroleptics, the severe and potentially lethal consequences of Neuroleptic Malignant Syndrome are going unrecognized in psychiatric and forensic hospitals.¹ The result is that patients subjected to the drugs in these

¹The *Amici* submitting this brief are in a unique position to be aware of the dangers and harms of these drugs to patients because the investigation of abuses and deaths that result from drugs is part of their statutory mandate and their daily advocacy caseloads.

facilities are dying.

The forced use of neuroleptic drugs is an extraordinary intrusion on a person's privacy and bodily integrity. Absent an emergency, judicial review of the patient's competence to refuse or consent is required before the state can forcibly inject such potentially dangerous and debilitating drugs. Psychiatrists and institutional officials are simply not in a position to replace judicial review and make the decision to override a competent patient's drug refusal.

Not only is competence a judicial determination, but there is an inherent conflict in the decision making process of the staff of the institution which prevents them from adequately taking into account the needs of the patients and their right to refuse medication. Issues other than the health and needs of the patient take priority.

The medical staff's concern for the control and management of the facility results in the decision to forcibly drug. The result is that the legitimate concerns and objections of the patient succumb to the desires of the institution. However, it is the patient who is forced to unwillingly assume the risks and potential dangers of the drugging.

ARGUMENT

POINT I

THE FORCIBLE ADMINISTRATION OF NEUROLEPTIC DRUGS PROFOUNDLY IMPLICATES A PERSON'S BODILY AUTONOMY BECAUSE OF THE SERIOUS AND LETHAL HEALTH HAZARDS INHERENT IN THE USE OF SUCH DRUGS.

In concluding that a judicial hearing is required prior to the involuntary administration of neuroleptic drugs to a prisoner, the Washington Supreme Court properly held that the "highly intrusive nature of anti-psychotic drug treatment warrants greater protection than" the administrative process minimally required by this Court in *Vitek v. Jones*, 445 U.S. 480 (1980) prior to forced confinement. *Harper v. Washington*, 759 P.2d 358, 363 (Wash. 1988).

The intrusiveness of neuroleptic² drugs is not only evidenced by their well-established adverse physical side-effects, but there is an increasing recognition that these drugs cause a potentially lethal physical reaction known as Neuroleptic Malignant Syndrome, resulting quite frequently in a painful death for the person unwillingly subjected to them. While recent medical literature acknowledges that Neuroleptic Malignant Syndrome has been unrecognized and underdiagnosed in the United

²This brief shall use the term "neuroleptic" to refer to medications that are interchangeably termed in the literature as "neuroleptic", "major tranquilizer", "psychotropic" and "antipsychotic", since medical literature suggests that "neuroleptic" is more medically precise in describing the effects of the drugs and their capacity to affect the brain.

States, the frequency of its occurrence indicates that it is a neglected health hazard of major proportions considering the large number of patients treated with neuroleptics. A conservative estimate indicates that 30,000 patients on neuroleptics will suffer from Neuroleptic Malignant Syndrome and 6,000 of them will die. Caroff, *The Neuroleptic Malignant Syndrome*, 41 J. Clin. Psych. 79 (1980); Pope, Keck, McElroy, *Frequency and Presentation of Neuroleptic Malignant Syndrome in a Large Psychiatric Hospital*, 143 Am. J. Psych. 1227 (1986). As has already been judicially acknowledged: "few legitimate medical procedures . . . are more intrusive than the forcible injection of antipsychotic medication. . . . Because of the profound effect that these drugs have on the thought processes . . . and the well-established likelihood of severe and irreversible adverse side effects." *Guardianship of Roe*, 421 N.E.2d 40, 52-53 (Mass. 1981).

A. Neuroleptic drugs cause serious physical side effects

Courts throughout the United States have consistently recognized that neuroleptic drugs produce a wide range of unwanted and often unpredictable physical and mental side effects which can range from being relatively minor to totally debilitating.³ A total catalogue of the immediate and cumulative adverse effects caused by neuroleptic drugs "would be a horrendous document . . . ranging from dry mouth to death." Brooks, *The Constitutional Right to Refuse Antipsychotic Medication*, Bull. Am. Acad. Psych. and Law 179, 184 (1980).

This past year the Supreme Court of Minnesota found

³*Mills v. Rogers*, 457 U.S. 291, 293 n.1 (1982); *Davis v. Hubbard*, 506 F.Supp. 915, 928-29 (N.D. Ohio 1980); *People v. Medina*, 705 P.2d 961 (Colo. 1985).

the most common immediate side effects of neuroleptic drugs to include:

"the temporary, muscular side effects (extra pyramidal symptoms) which disappear when the drug is terminated, dystonic reactions (muscle spasms, especially in the eyes, neck, face and arms; irregular flexing, writhing or grimacing movements; protrusion of the tongue); akathisia (inability to stay still, restlessness, agitation); and Parkinsonism (mask-like face, drooling, muscle stiffness and rigidity, shuffling gait, tremors). Additionally, there are numerous other nonmuscular effects, including drowsiness, weakness, weight gain, dizziness, fainting, low blood pressure, dry mouth, blurred vision, loss of sexual desire, frigidity, apathy, depression, constipation, diarrhea, and changes in the blood." *Jarvis v. Levine*, 418 N.W.2d 139, 145 (Minn. 1988).⁴

To date, tardive dyskinesia, a permanently disabling form of brain damage resulting from the use of neuroleptic drugs, has generated the most attention in both the courts and the literature. This grotesque neurological disorder is manifested by uncontrollable distortions of the face, tongue, lips, mouth, jaw, arms, legs and trunk. It may "interfere with all motor activity, making speech, swallowing and breathing extremely difficult. . . . There is no known cure for the condition. . . . It is impossible to predict who will become its victim." *People v. Medina*, 705 P.2d at 961. One recent medical

⁴See also Plotkin, *Limiting the Therapeutic Orgy: Mental Patients' Right to Refuse Treatment*, 72 Nw.U.L. Rev. 461 (1977); Hollister, *Antipsychotics and Antimanic Drugs in Review of General Psychiatry*, 596 Goldman ed. (1984).

report of the death of a patient from tardive dyskinesia, found that the potential for serious motor disability is generally underestimated. The report described the patient as suffering from persistent retching, vomiting and weight loss and finally respiratory collapse. Lazarus & Toglia, *Fatal Myoglobinuria Renal Failure in a Patient of Tardive Dyskinesia*, 35 Neurolog. 1055, 1057 (1985).

Initially much of the psychiatric profession resisted acknowledging even the very existence of tardive dyskinesia. At worst, the profession considered it to be a rare and insignificant syndrome. Psychiatrists often claimed that the symptoms of tardive dyskinesia were not due to the drugs being given to their patients. Crane, *Clinical Psychopharmacology in its 20th Year*, 181 Science 124, 127 (1973); Brown, *Tardive Dyskinesia: Barriers to the Professional Recognition of an Iatrogenic Disease*, 26 J. Health and Soc. Beh. 116 (1986). Literature now shows that neuroleptic drugs cause tardive dyskinesia in up to 50% of the patients given these drugs, and this figure continues to rise. De Vaugh-Geiss, *Tardive Dyskinesia and Related Involuntary Movement Disorders* (1982); Gualtieri, Sprague, and Cole, *Tardive Dyskinesia Litigation and the Dilemmas of Neuroleptic Treatment*, 14 J. Psych. and Law 187 (1986). While the prevalence rate of tardive dyskinesia grows year by year, making tardive dyskinesia a major public health hazard, there still continues to be an alarming rate of underdiagnosis of this neurological disability. Weider, Mann, Hass, Mattsen and Frances, *Clinical Non-Recognition of Neuroleptic-Induced Movement Disorder: A Cautionary Study*, 144 Am. J. Psych. 1148 (1987).

An equally disabling disorder resulting within hours of the use of neuroleptic drugs, akathisia, is also

frequently unrecognized and misdiagnosed. This disorder is generally marked by an uncontrollable physical restlessness and agitation and by interminable pacing, shaking of arms and legs, foot bouncing, and anxiety or panic. Brooks, *The Right to Refuse AntiPsychotic Medications: Law and Policy*, 39 Rutgers L. Rev. 339, 348 (1987).

Akathisia occurs in over 20% of patients who receive neuroleptic drugs and its symptoms may include feelings of fright, rage, terror and sexual torment. The overwhelming and intense nature of the patient's experience may actually lead to acts of violence and even attempts at suicide. Krupp, Schoeder, Tierney, eds., *Current Medical Diagnosis and Treatment 1987*, (1987); Braude, et al, *Clinical Characteristics of Akathisia: A Systemic Investigation of Acute Psychiatric Inpatient Admissions*, 143 Brit. J. Psych. 139 (1983). The distress, pacing and suicidal behavior induced by these drugs are often misinterpreted by clinicians as a worsening of the psychosis, rather than a sign of akathisia. Consequently, rather than discontinuing the drugs, the dosage is increased and the patient's condition actually worsens. Drake and Erlich, *Suicide Attempts Associated with Akathisia*, 142 Am. J. Psych. 499 (1985); Lancet, *Akathisia and Anti-Psychotic Drugs*, 1131 (1986).

B. Neuroleptic drugs pose a serious risk of death

While the effects of neuroleptic drugs described above present debilitating and agonizing physical, emotional and cognitive side effects, a potentially lethal result of neuroleptic use, Neuroleptic Malignant Syndrome, is

becoming increasingly observed in psychiatric patients.⁵

The onset of Neuroleptic Malignant Syndrome may occur at any time, including hours to months after exposure to the drug. It is not related to the duration of exposure to neuroleptics or to toxic overdoses. All patients given neuroleptic drugs are at risk.

Once begun, Neuroleptic Malignant Syndrome explodes rapidly over a one to three day period. It can lead to irreversible brain damage, renal failure, cardiac collapse, dehydration, and death. Even with survival, the patient may end up dependent on mechanical maintenance of life, or may suffer an extended disability from muscle deformity, muscle destruction, renal impairment, and heat stroke encephalopathy, accompanied by fear of all medications, physicians and hospitals. George and Baxter, *Neuroleptic Malignant Syndrome*, 313 New Eng. J. Med. 163 (1985); Mueller, *Neuroleptic Malignant Syndrome*, 26 Psychosomatics 654 (1985).

Victims of Neuroleptic Malignant Syndrome develop high fevers (up to 108°) and extreme muscle rigidity. They may become confused and totally mute. Sometimes they sweat profusely and drool. The muscle rigidity that develops (often described as "lead-pipe") can involve more than just a person's extremities, it can be extremely painful, leading to muscle breakdown, renal failure and death. The high fever, hyperthermia, may lead to heat stroke, irreversible brain damage, coma and finally

⁵Yet another recently identified, though not fatal, hazard of neuroleptic drugs is Meige's Syndrome. It results in uncontrollable eyelid spasms that can lead to the total obstruction of a person's vision. Ananth, Edelmuth and Dargan, *Meige's Syndrome Associated with Neuroleptic Treatment*, 145 Am. J. Psych. 513 (1988).

death. Caroff, *supra*; Sternberg, *Neuroleptic Malignant Syndrome: The Pendulum Swings*, 143 Am. J. Psych. 1273 (1986). However, Neuroleptic Malignant Syndrome remains an underdiagnosed health hazard, going unrecognized in even the most sophisticated private psychiatric hospitals. Pope, Keck, McElroy, *supra*. Significant numbers of patients subjected to neuroleptic drugs are suffering its drastic consequences and many of them are dying.

This underdiagnosis and underrecognition is strikingly similar to the failure of the psychiatric community to accept the existence of tardive dyskinesia, now known to affect up to 50% of persons receiving neuroleptics. In reaction to the continuing evidence of Tardive Dyskinesia, the "majority of psychiatrists either ignored the existence of the problem or made futile efforts to prove that the effects on patients were clinically insignificant or unrelated to drug therapy." Crane, "Preface" in *Tardive Dyskinesia: Research and Treatment* (Fann, Smith, Davis and Domino, eds. 1980).

Even while underdiagnosed, it is estimated that 20-30% of those persons afflicted with Neuroleptic Malignant Syndrome die as a direct result. The forced drugging of a patient significantly increases that risk of death. This results from the institutional reality that when patients refuse to take the drugs orally, they are subsequently injected by staff. The use of intramuscular neuroleptics, however, dramatically increases the risk of death from Neuroleptic Malignant Syndrome to 38%. The magnitude and severity of this public health problem is evident when it is recognized that approximately three million Americans are currently receiving neuroleptics, that 945,000 new patients receive the drugs each year and that from 1.4% to 2.4% will suffer from Neuroleptic

Malignant Syndrome. The inevitable result is that Neuroleptic Malignant Syndrome will afflict "thousands of cases, a significant number may have fatal consequences." Even by the most conservative of estimates, 30,000 Americans yearly will be suffering the effects of Neuroleptic Malignant Syndrome and over 6,000 of them will die as a result. Pope, Keck, McElroy, *supra* at 1232; Addonizio, Susman, and Roth, *Symptoms of Neuroleptic Malignant Syndrome in 82 Consecutive Inpatients*, 143 Am. J. Psych. 1587 (1986).

While a recent review of the medical literature reveals that Neuroleptic Malignant Syndrome has caused psychiatric patients to die from such varied complications as cardiopulmonary arrest, pneumonia, blood clots, sepsis, and kidney failure, Addonizio, Susman, and Roth, *Neuroleptic Malignant Syndrome: Review and Analysis of 115 cases*, 22 Biol. Psych. 1004 (1987),⁶ a recent report issued by the New Jersey Department of the Public Advocate describes the deaths of four patients caused by neuroleptic drugs.⁷ In two of these cases, the patients smothered to death in their pillows. The muscular rigidity caused by Neuroleptic Malignant Syndrome was so severe that, while lying in bed, they could not turn their heads to breathe.

One of these men, 25 years old, while on neuroleptics began to exhibit behavior that included squirming on the floor and kicking at people passing in the hallways

⁶See also Levenson, *Neuroleptic Malignant Syndrome*, 142 Am. J. Psych. 1141 (1985), a study of patients suffering from Neuroleptic Malignant Syndrome in which 10 of the 53 patients had acute renal failure requiring the use of a dialysis machine.

⁷New Jersey Department of the Public Advocate, *Investigation of the Circumstances of the Deaths of V.B., G.O., D.W. and S.A.*, (1988).

of his ward. This behavior led to injections of neuroleptic drugs. Over the next few days he began rubbing his bare toes against the floor until they bled, his limbs contracted while he lay in bed shaking, mumbling, and sweating profusely. This was followed by a fixed staring gaze with dilated pupils with his mouth hanging open. Neuroleptic Malignant Syndrome was not diagnosed. He was found dead lying face down in the pillow. The cause of death was Neuroleptic Malignant Syndrome.

A second man, 20 years old, was allowed to refuse drugs until he broke one of the ward rules. He was then forcibly injected. One day later, he was found lying on his back with his tongue protruding outward, his head contorted in a grotesque position, unable to speak. When these reactions subsided, his dosage was increased and physical reactions to the drugs continued. His mother and uncle found him stiff as a board when they visited him during the last days of his life. The day before he died, he was drooling, shuffling around the ward with his arms out stiffly from his side, needing assistance getting in and out of the shower and in dressing. The next morning, he was found dead in his bed, face down in his pillow. The county medical examiner determined that the severe muscle stiffness resulting from Neuroleptic Malignant Syndrome had prevented him from turning over, thus resulting in death by suffocation. In this young man's case, the use of neuroleptic drugs as a chemical restraint and punishment resulted in his painful, humiliating and unnecessary death.

Another complication of Neuroleptic Malignant Syndrome, hyperthermia, was described in the death of a third New Jersey man. He had been receiving neuroleptic drugs for six months. On a hot humid day

in August, on a ward without air-conditioning, he was found lying on his back gurgling and vomiting. Already suffering from hyperthermia, he was unconscious. His body temperature was 106°F, his blood pressure dangerously low and his pulse was racing. He died within 30 minutes. According to the county medical examiner, he died from hyperthermia related to the onset of Neuroleptic Malignant Syndrome and fluid in his lungs caused by aspiration of his own vomit.

A similar death is presently being investigated in California. A 23 year old man died while locked on the ward of a state psychiatric hospital on a hot day in September 1988. He was given drugs despite his stated refusal. The coroner has ruled that his death was caused by the extreme heat and dehydration, caused by the drugs he was given. One hour after he had died, his body temperature was still 104°.

The fourth case included in the 1988 New Jersey report is that of a 22 year old patient receiving both neuroleptics and a drug to counteract side effects. When the temperature outside was 92°, he was given a day pass to celebrate the 4th of July with his family. After an afternoon at the beach, they returned to their mother's house, where the patient suddenly collapsed and died of heat stroke.

As demonstrated by the deaths described above, neuroleptics can markedly impair the body's ability to regulate its own temperature. As a result, persons subjected to neuroleptics can actually become "cold-blooded," and their body temperatures become dependent upon the ambient environmental temperature around them. This effect is compounded by the fact that anticholinergic drugs, often prescribed to counteract the side effects of neuroleptics, also interfere with the

body's ability to regulate its own temperature and make the hyperthermia worse. Heat stroke, as a result of neuroleptic drugs, occurs when the patient is subjected to neuroleptics and exposed to hot, humid weather or excessive agitation or exercise. Caroff, *supra*; Haggerty, Bertsen and Gillette, *Neuroleptic Malignant Syndrome Superimposed in Tardive Dyskinesia*, 150 Brit. J. Psych. 104 (1987).

The danger of heat stroke is obvious to anyone touring the wards of any state or forensic psychiatric hospital on a midsummer day. Few wards, if any, are air-conditioned and fans, when available, do little to lower the actual temperature of the ward. The buildings tend to be old, poorly ventilated, and very hot. Temperature regulation is simply not possible. Most patients and inmates do not even have the ability to remove themselves from these dangerously hot settings, since the wards are often locked and the patients are involuntarily confined to them. Even with the ability to go outdoors, which most inmates are not allowed to do, the risk of lethal hyperthermia exists on hot days. Mann and Boger, *Psychotropic Drugs, Summer Heat and Humidity, and Hyperpyrexia: A Danger Restated*, 135 Am. J. Psych. 1097, 1099 (1978).

As illustrated by the fatal results of the use of neuroleptic drugs, and as succinctly stated by the Wisconsin Supreme Court: "[I]t is undisputed that conditions caused by some of the side effects are often times irreversible and can even be fatal. One does not need a medical degree to realize we are not discussing Aspirin." *Wisconsin ex rel. Jones v. Gerhardstein*, 416 N.W.2d 883, 890 (Wis. 1987).

C. The intrusiveness of neuroleptic drugs requires judicial review prior to involuntary administration

The *amicus* brief submitted to this Court by the American Psychiatric Association (APA) contends that the "supposed intrusions of anti-psychotic drug therapy are largely illusory." Brief for the American Psychiatric Association at 24 (No. 88-599). The deaths of patients in state-run institutions are not illusory. It is hard to fathom consequences of state action that are more intrusive, more debilitating and painful, and more severe than that described above and that suffered by patients who are unwillingly subjected to these potentially lethal drugs. Neuroleptic drugs may benefit some patients, but others suffer, and may die, as a result of their use.

While the APA further contends that there is no factual, medical or constitutional basis to distinguish use of neuroleptic drugs and the involuntary confinement contemplated in *Vitek*, the Washington Supreme Court properly held that the highly intrusive nature of these drugs, the significant risks of adverse permanent side effects, debilitation, and death, require greater protection. While the forced confinement contemplated in *Vitek* is a significant infringement on the liberty of a prisoner or a psychiatric patient, the forcible administration of potentially lethal drugs requires a greater degree of constitutional protection. The very purpose of neuroleptic drugging in many cases is not for medical treatment, and is not necessarily based solely upon medical judgment. Rather, in locked settings, such as that experienced by Respondent Harper, the use of these drugs is often for the very purposes of controlling, incapacitating, or punishing the patient. In most of these situations a patient refusing drugs will have the drugs injected by staff. As described above, the use of

intramuscular neuroleptics actually increases the mortality rate of Neuroleptic Malignant Syndrome to 38%. Thus, overriding a patient's refusal of drugs by forcible injection significantly increases the intrusiveness of the drug and the risk of a fatal result.

Not only does the intrusiveness of neuroleptics go far beyond that contemplated in *Vitek*, but it goes beyond that which led to this Court's decision in *Youngberg v. Romeo*, 457 U.S. 307 (1982). *Youngberg* involved the use of soft arm restraints to protect an incompetent patient and others from injury. *Harper* is a case of a competent person wishing to refuse chemical restraints in a nonemergency situation. It is about the forcible administration of neuroleptic drugs and the myriad of physical consequences suffered by a patient as a result of an institutional decision to impose these drugs.

There is simply no comparison between restraining a patient with soft arm restraints and chemically restraining with potentially lethal drugs. The intentional use of powerful drugs with long-term neurological and physical ramifications, including death, requires more protection. The risks and intrusiveness are of a greater magnitude and consequently require a higher level of scrutiny and oversight: "the 'professional judgment' of medical personnel insufficiently protects the basic human right not to have one's own body altered or invaded without consent." *Jarvis v. Levine*, 418 N.W.2d at 148.

POINT II

ABSENT AN EMERGENCY, THE DECISION TO FORCIBLY DRUG A PSYCHIATRIC PATIENT SHOULD ONLY BE MADE AFTER A JUDICIAL DETERMINATION OF INCOMPETENCE AND SHOULD NOT BE LEFT TO MEDICAL STAFF

A. Medical staff of psychiatric institutions are not neutral decision makers and their interests directly conflict with the patient's interest in refusing neuroleptic drugs

The inherent conflicts within the psychiatric institution and the dual loyalties of psychiatrists to both the institution and the patient prevent them from making independent judgments regarding a patient's decision to refuse potentially lethal drugs in non-emergency situations. This conflict prevents them from being impartial decisionmakers, and actually leads to the use of neuroleptic drugs for control and chemical restraint. The refusing patient is then subject to the serious and potentially lethal effects of the drugs even when they are not receiving the "benefit" of the drug. Actually, it is the institution which is receiving the benefit of the drug while the patient unwillingly assumes the risks.

Institutional doctors "who are attempting to treat as well as to maintain order in the hospital have interests in conflict with those of their patient who may wish to avoid medication." *Rogers v. Comm. of the Dep't of Mental Health*, 458 N.E. 2d 308, 317-18 (Mass. 1983). In addition to taking into account the needs of the patient, they take into account the concerns and interests of the nurses and ward staff with whom they must deal

on a daily basis. Patients medicated to the point where they present no behavior problems and who are compliant with hospital routines will ease ward management and will make the job of nurses and attendants easier. Management, control, and expedience take on enormous importance and become a guiding principle in institutional settings. In essence, control becomes "the treatment goal, and medication the chief method of achieving control" in psychiatric institutions. *Care of Institutionalized Mentally Disabled Persons: Joint Hearing Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Human Resources*, 99th Cong. 1st Sess. 68 (1985).

While these concerns actually conflict with the health of the patient, they are frequently controlling when neuroleptic drugs are ordered in institutions. Brooks, *The Right to Refuse Antipsychotic Medications: Law and Policy*, *supra*, at 346. The use of neuroleptics for control and the management of inmates, instead of for the needs of patients, is especially true in prison settings and forensic hospitals where control is an accepted goal of the institution. See *Bee v. Greaves*, 744 F.2d 1387 (10th Cir. 1984).

While the medical profession may claim that professional judgment will adequately protect inmates from the harm of neuroleptic drugs, that is not the case. The practice of institutional psychiatry is very different from the practice of medicine in any other setting. In other aspects of medicine, the doctor has only the patient and his treatment in mind. Institutional psychiatry forces the doctor to consider security and staff desires above the needs of the patient. A doctor would never perform minor surgery or any other procedure on a patient for the convenience of staff, or for any reason other than

the needs of the patient or a life-saving emergency. Yet, in institutional settings, drugs, more dangerous than minor surgery are routinely forced on patients for these very reasons. The professional judgment standard simply does not protect the interests of the patient since "it does not adequately take into consideration the fact that the psychiatrist has competing interests in providing treatment to the patient, protecting his other patients and the staff of the facility and attempting to secure the patient's earliest release from the facility." *In re The Mental Commitment of M.P.*, 510 N.E.2d 645, 647 (Ind. 1987).

B. The judiciary is the only forum to determine if a patient is competent to refuse neuroleptic drugs

A judicial hearing prior to forced drugging, absent an emergency, is mandated by the intrusiveness and potentially lethal consequences of the drugging (see Point I), and by the conflicts which prevent psychiatrists from making balanced, independent decisions regarding a patient's refusal of drugs (above). Additionally, as required by numerous state courts, including the court below, competency to consent to neuroleptic drugs is a legal determination, not a medical one, and can only be made by an appropriate court of law.⁸

The need for judicial review was clearly enunciated by the Supreme Court of Colorado: "[A]lthough the decision to forcibly medicate a patient with antipsychotic drugs understandably involves an aspect of professional medical judgment in connection with psychiatric diagnoses and treatment alternatives, the fact remains

⁸*Jarvis v. Levine*, 418 N.W.2d at 147-48; *Wisconsin ex rel. Jones v. Gerhardstein*, 416 N.W.2d at 898; *Rivers v. Katz*, 495 N.E.2d 337, 343-44 (N.Y. 1986).

that the decision itself directly implicates the patient's legal interests in personal autonomy and bodily integrity." *People v. Medina*, 705 P.2d at 969.

Leaving competency determinations to medical staff creates a significant risk that simply because the professional believes the patient has made the "wrong" decision, the conclusion will be made that the patient is incompetent. However, "the fact that a mental patient may disagree with the psychiatrist's judgment about the benefit of medication outweighing the costs does not make the patient's decision incompetent." *Rivers v. Katz*, 495 N.E.2d at 342.

The risks to the patient are high, and the potential that exists for competent individuals to be declared incompetent by hospital staff for purposes of convenience, control, or expedience can only be avoided by the objectivity of judicial review. Due to the dangers posed by well-intentioned but potentially biased judgments, "under our Constitution, there is no procedural right more fundamental than the right of the citizen, except in extraordinary circumstances, to tell his side of the story to an impartial tribunal." *Winters v. Miller*, 446 F.2d 65, 71 (2d Cir. 1971), *cert. denied*, 404 U.S. 985 (1971). This Constitutional requirement should not be turned on its head to mean that if a competent person chooses not to undergo the risks or pains of a potentially dangerous treatment, an inherently partial institutional professional may force him to accept it.

Furthermore, it must be recognized that competent patients are in the best position to decide whether the benefits of medication outweigh the risks. Diamond, *Drugs and the Quality of Life: The Patient's Point of View*, 46 J. Clin. Psych. 29 (1985). Doctors consistently

fail to recognize and treat side effects from medication or properly take into account the risks of treatment. Clinicians also do not correctly diagnose the side effects of drugs when recognized, minimize the severity of the reactions, and fail to treat them to an alarming extent. Weiden, Mann, Haas, Mattson, and Frances, *supra*; *Davis v. Hubbard*, 506 F. Supp. at 936. When clinicians do recognize side effects, they often characterize them as "faked." *Rennie v. Klein*, 476 F. Supp. 1294, 1301 (D.N.J. 1979). Consequently, without a judicial finding of incompetence "it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires." *Rivers v. Katz*, 495 N.E.2d at 341.

Absent an emergency, the state simply does not have a compelling need to subject a competent person to forced drugging. In *Winston v. Lee*, 470 U.S. 753 (1985), in which the State of Virginia sought to forcibly drug a prisoner with a general anaesthetic and remove a bullet over his objections, this Court held that even where the medical risks "although apparently not extremely severe, [and] are a subject of considerable dispute; the very uncertainty [of the risk] militates against finding" the procedure to be reasonable. *Id.* at 784. This Court recognized that when the state seeks to take control of a prisoner's body and drug him, it would then be an "extensive intrusion on the respondent's personal privacy and bodily integrity." *Id.* This Court prohibited such state action absent a compelling interest.

The forcible injection of neuroleptics, with its neurological, physical, and potentially lethal consequences, is at least as intrusive as Virginia's efforts to require

a prisoner to undergo anaesthesia and the removal of a bullet. As in *Winston*, the intrusion of forced neuroleptic drugs on a patient's privacy interests "can only be characterized as severe," *Id.* at 765, and can only be countenanced with the establishment of a compelling state interest. In the case before this Court, no police power emergency situation exists. Consequently, the state has no compelling interest to force a legally competent inmate to have potentially dangerous and lethal drugs injected into his body. Only in a police power emergency should a patient be subjected to a treatment that may very well be worse than the cure.

In settings similar to the one in which Respondent Harper was placed, the California Court of Appeal has required judicial review prior to the involuntary use of neuroleptics on prisoners. *Keyhea v. Rushen*, 178 Cal. App. 3d 526 (1986). The Court of Appeal has also mandated that judicial review include a finding that a less intrusive intervention cannot be utilized. *People v. Woodall*, 209 Cal. App. 3d 925 (1989). Less restrictive alternatives to neuroleptic drugs may very well include physical restraints or seclusion, which are temporary and have no long-term effects. Inquiry into alternatives which will satisfactorily provide for prison or hospital security may also help prevent the improper use of drugs for the convenience of institutional staff.

C. Judicial review of drug refusal has been successfully implemented in many states

Requiring judicial review will protect the patient's profound interest in preserving his bodily autonomy and weighing the risks of the drug. Such review will not, however, unduly burden governmental interests in institutional efficiency and treatment.

The psychiatric community has historically proclaimed disaster at the prospect of judicial intervention in what they believed to be a purely medical matter. Not only is forced drugging not merely a medical matter, but judicial intervention has not led to disaster. In fact, it has produced positive results for both patients and the institution. The Court of Appeal in California has recently recognized that there has not been a massive wave of drug refusals which clinicians had initially predicted would cause chaos and disruption in psychiatric hospitals: "[R]esearch indicates that the epidemic of refusals feared after early litigation of the right to refuse antipsychotic medication has not materialized and that refusal has not led to increased accidents or injuries to patients or staff." *Riese v. St. Mary's Hospital*, 196 Cal. App. 3d 1388, 1404 (1987).

It has also been widely recognized that enabling patients, through refusal of the drug prescribed, to have a voice in decisions about their treatment actually has positive advantages in developing an effective therapeutic alliance. Applebaum and Gutheil, *Drug Refusal: A Study of Psychiatric Patients*, 137 Am. J. Psych. 340 (1980).

A recent California study found that mutual participation of staff and patients in the informed consent process at a crisis center had a therapeutic benefit and frequently resulted in the patient consenting to medication. Thus, even at facilities dealing with psychiatric emergencies and persons suffering from acute psychotic episodes, negotiations are successful in the vast majority of cases. Resort to the legal process is only required in those cases where informed consent cannot be obtained or the doctors refuse to negotiate with their patients. Ghannum & Gresham, *Informed Consent to*

Receive Antipsychotic Medication in Involuntarily Detained Psychiatric Patients (1988).

Judicial review has also produced positive changes in the Massachusetts mental health system. Subsequent to the *Rogers* decision, neuroleptic drugs for a significant number of patients were either reduced or terminated when the patient initially refused the presented drugs and the psychiatrist reviewed their cases prior to filing for judicial review. These patients improved and suffered fewer negative reactions and drug induced disabilities caused by the drugs. No increase in accidents or injuries to staff or patients took place, mental health professionals did not flee the system, and there was no increase in the patient's length of stay at the institution. Schwartz, *Equal Protection in Medication Decisions: Informed Consent, Not Just the Right to Refuse*, in ABA, *The Right to Refuse Medication* (1986).

There has been no evidence that patients are adversely affected by any delay that might result from the scheduling of a competency hearing, Brooks, *The Right to Refuse Antipsychotic Medications: Law and Policy*, *supra* at 370, or that patients who refused their neuroleptic drugs would become violent and disruptive. Zito *et al.*, *Clinical Characteristics of Hospitalized Psychotic Patients Who Refuse Antipsychotic Drug Therapy*, 142 Am. J. Psych. 822 (1985). Patients who refuse neuroleptic drugs are no more threatening or assaultive than those patients who consent to their medications, and willingly participate in other parts of their treatment program. In fact, the use of external controls such as seclusion and restraint are not used more frequently with patients who object to the prescribed drugs. *Id.* at 825-26.

In addition to the fact that institutions are no less

safe when informed consent and judicial review are required, there have actually been measurable benefits through a reduction in abusive and substandard practices. Medications are more often reduced or changed when a patient refuses because of painful or distressing side effects. The prospect of judicial oversight has increased attention to a patient's negative reaction to the drugs prescribed, and increased the willingness to accommodate the patient's needs. Most importantly, negotiations between doctor and patient has led to changes in the amount or type of medication rather than a hearing. Brooks, *The Right to Refuse Antipsychotic Medications: Law and Policy*, *supra* at 369.

In fact, the state mental health programs in those states where judicial review is required prior to the forced administration of neuroleptic drugs have actually been improving. A 1988 survey, rating all state mental health programs, has determined that those states which have affirmed the patient's right to refuse neuroleptic drugs have continually improving mental health systems. E.F. Torrey and S. Wolfe, *Care of the Seriously Mentally Ill: A Rating of State Programs* (2d Ed. 1988).

Conclusion

The judgment of the Supreme Court of Washington should be affirmed.

Respectfully Submitted,

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I, the undersigned, say: I am and was at all times herein mentioned, a citizen of the United States and a resident of the County of Los Angeles, over the age of eighteen (18) years and not a party to the within action or proceeding; that my business address is 11333 Iowa Avenue, Los Angeles, California 90025; that on June 29, 1989, I served the within *Brief of the National Association of Protection and Advocacy Systems, National Association for Rights Protection and Advocacy, Protection and Advocacy, Inc. and Michigan Protection and Advocacy Inc., Supporting Respondent* in said action or proceeding by depositing true copies thereof, enclosed in a sealed envelope with postage thereon fully prepaid, in the United States mail at Los Angeles, California, addressed as follows:

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I declare under penalty of perjury that the foregoing is true and correct. Executed on June 29, 1989, at Los Angeles, California.

Betty J Malloy
(Original signed)

AMICUS CURIAE

BRIEF

(13)
NO. 88-599

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IN THE
Supreme Court of the United States
October Term, 1988

STATE OF WASHINGTON, et al.,

Petitioners,

v.

WALTER HARPER,

Respondent

ON WRIT OF CERTIORARI TO THE
SUPREME COURT OF WASHINGTON

BRIEF FOR THE NEW JERSEY DEPARTMENT
OF THE PUBLIC ADVOCATE AS AMICUS
CURIAE IN SUPPORT OF RESPONDENT

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INTEREST OF AMICUS CURIAE

The New Jersey Department of the Public Advocate, through its Division of Mental Health Advocacy, submits this amicus curiae brief in support of Walter Harper, and urges this Court to affirm the judgment of the Supreme Court of Washington, holding unconstitutional the medication refusal policy of the State's prison for mentally ill inmates.

Amicus is a cabinet-level state agency that has represented psychiatric patients for 15 years in a wide range of matters including civil commitment, civil commitment of prisoners and medication refusal, pursuant to enabling legislation, N.J.S.A. 52:27E-21 through 27. In civil commitment cases alone, the Division of Mental Health Advocacy has represented individuals at more than 95,167 hearings since its inception. Ten

years ago, amicus represented the plaintiff class in Rennie v. Klein, 462 F. Supp. 1131 (D.N.J. 1978), 476 F. Supp. 1294 (D.N.J. 1979), modified and rem'd 653 F. 2d 836 (3d Cir. 1981) (en banc), vacated and rem'd 458 U.S. 1119, 102 S.Ct. 3506 (1986) on remand 720 F. 2d 266 (3d Cir. 1983) (en banc) which was one of the first cases in the United States to determine the right of psychiatric patients to refuse psychotropic medication.

The Rennie decision established a qualified constitutional right to refuse psychotropic medication, providing for the state to override the patient's refusal through a hospital-based peer review process. The New Jersey review process is similar to the policy which the Washington Supreme Court, in the case at bar, found to be constitutionally

inadequate. Amicus has monitored the effect of this type of internal review process since 1981 and is in the unique position of being able to report to this Court on significant problems associated with it, and upon the inability of such an internal review process to adequately vindicate the constitutional right which is at stake.

Additionally, amicus is the federal Protection and Advocacy System for Mentally Ill Individuals in New Jersey, pursuant to 42 U.S.C.A. 10801 et seq. In this capacity, the agency has conducted in-depth investigations into four medication-related deaths at New Jersey state hospitals and found that they were preventable, resulted from the administration of anti-psychotic medication in a manner which was below accepted medical standards and in a

manner which recklessly ignored clear signs of life-threatening and known side-effects. Those investigations disclosed the clear failure of hospital officials to correct obvious deficiencies before they resulted in subsequent deaths.

Because the Washington Supreme Court's opinion applies to both mentally ill prisoners and civilly committed individuals, State of Washington v. Harper, 110 Wash. 2d 873, 882 (1988), this Court's review and decision will potentially affect the hundreds of clients amicus currently represents in medication refusal matters.

FILING BY CONSENT

Amicus has obtained the written consent of petitioner and respondent to the filing of the within brief, pursuant to Rule 33. Such consents have been filed with the Clerk.

SUMMARY OF ARGUMENT

The use of psychotropic drugs carries substantial risks including the risk of death from neuroleptic malignant syndrome and hyperthermia. The potential of death is in addition to the risk of painful and temporary side effects, and permanent and disfiguring neurological damage from tardive dyskinesia. Psychotropic drugs have caused the premature death of four young men in New Jersey, as established in official investigations conducted and published by amicus. Psychotropic drugs are major tranquilizers that not only mask some of the major symptoms of psychoses, but also heavily sedate the body of the patient. State action forcing these effects on unwilling and vulnerable patients must carry substantial due process protection to ensure that the risk of error and the

risk of harm are reduced to the lowest possible level.

In New Jersey a system of internal peer review similar to the Special Offender Center policy in Harper has proven ineffective in ensuring that medication refusals are carefully reviewed. The New Jersey internal peer review system is that which was approved by the Third Circuit in Rennie v. Klein, supra. As is demonstrated herein, external review of medication refusals resulted in the total discontinuation or the reduction of medication in 59% of the cases where state hospital patients refused prescribed anti-psychotic medication. In stark contrast, purely internal peer review resulted in a total discontinuation or a reduction of dosage in a mere 2.47% of the refusal cases. Thus, only external review reduces the

risk of harm and the risk of error to constitutionally acceptable levels.

External review is not unduly costly or burdensome, does not disrupt institutional order and results in improved quality of care and treatment.

The legal standard to be applied to determine what process is due to patients who refuse psychotropic medication is established by Mathews v. Eldridge, 424 U.S. 319, 96 S.Ct. 893 (1976). When the three-prong Mathews test is applied to this case, it is undeniable that the nature of the private interest includes avoiding the risk of death, that the risk of error is substantial because of the failure of state physicians to acknowledge life threatening, painful or disfiguring side effects and that the governmental interest in avoiding

additional fiscal or administrative burdens is not unduly affected.

- I. THE NEEDLESS DEATHS OF FOUR YOUNG NEW JERSEY MEN AS A DIRECT RESULT OF ANTI-PSYCHOTIC MEDICATION ADMINISTERED BY STATE OFFICIALS DEMONSTRATE THAT THE RISK OF HARM AND THE RISK OF ERROR MAKE JUDICIAL REVIEW ESSENTIAL

The nature of Walter Harper's private interest in avoiding unwanted mind-altering medication and the risk of an erroneous decision by prison officials are so great that judicial review is the sole mechanism which will satisfy constitutionally mandated due process. As is demonstrated by the needless deaths of four young men in New Jersey as a direct result of anti-psychotic medication administered to them by state officials, the risk of harm includes death, and the risk of an erroneous

decision by state officials is high because of institutional reluctance to even acknowledge drug side-effects.

- A. Because anti-psychotic medication can cause death, as it has in New Jersey, the private interest in avoiding forced drugging is substantial

The private interest of an individual in avoiding forced drugging is far more substantial than the record in this case establishes. While the Harper record does contain evidence of many of the grave risks associated with anti-psychotic medication, such as dystonia, akathesia, pseudo-Parkinsonism and the dreaded tardive dyskinesia, 110 Wash. 2d at 877-878, it does not contain any evidence regarding neuroleptic malignant syndrome (NMS) or hyperthermia. Both of these are potentially fatal complications

of anti-psychotic medication.¹ Neuroleptic malignant syndrome occurs in 0.5% to 1.0% of all patients taking anti-psychotic medication.² The incidence rate for hyperthermia is not documented in the psychiatric literature. Neuroleptic malignant syndrome alone causes death in 20% to 38% of all persons who develop it while taking psychotropic

1. "Sudden Death in Psychiatric Patients: The Role of Neuroleptic Drugs," American Psychiatric Association Task Force Report (Washington, D.C.: 1987); Caroff, S.N., "The Neuroleptic Malignant Syndrome," 41 Journal of Clinical Psychiatry 79 (1980); Mueller, "Neuroleptic Malignant Syndrome," 249 Journal of the American Medical Association 386 (1983);

2. Guze, B. and Baxter, L., "Current Concepts: Neuroleptic Malignant Syndrome," 313 New England Journal of Medicine 163 (1985); Caroff, S., "The Neuroleptic Malignant Syndrome," 41 Journal of Clinical Psychiatry 79 (1980).

drugs.³ In any one year, if 0.75 percent of all patients taking medication develop neuroleptic malignant syndrome, (0.75 is the average of 0.5% and 1.0%, as set forth in footnote 2),⁴ and one-third

3. The mortality rate of those developing neuroleptic malignant syndrome ranges from 20%, see Mueller, "Neuroleptic Malignant Syndrome," 249 Journal of the American Medical Association 386 (1983); American Psychiatric Association, Sudden Death in Psychiatric Patients: The Role of Neuroleptic Drugs, (Washington, D.C.: 1983); Shalev, "The Role of External Heat Load in Triggering the Neuroleptic Malignant Syndrome," 145 American Journal of Psychiatry 110 (1988) to 30-38%, see Goldwasser and Hooper, "Neuroleptic Malignant Syndrome," 38 American Family Physician 211 (1988) and Caroff, S.N., "The Neuroleptic Malignant Syndrome," 41 Journal of Clinical Psychiatry 79, 83 (1980).

The higher figure, of 30% to 38% mortality rate for those with neuroleptic malignant syndrome is for persons receiving the medication by intramuscular injection, while the 20% rate is for oral dosage. Mueller, "Neuroleptic Malignant Syndrome," 26 Psychosomatic No. 8 (1985)

4. See footnote 2, supra.

of them were to die,⁵ 875 patients a year can be expected to die of neuroleptic malignant syndrome each year, assuming that all or nearly all patients receive anti-psychotic medication at some time during their hospitalization. Over ten years, 8,750 can be expected to die.

In view of the estimated 17,000 individuals refusing medication in state-operated hospitals around the nation each year,⁶ a reversal by this Court of the

5. See footnote 3, supra.

6. In 1983, a study by the National Institute of Mental Health established that 343,774 individuals were admitted to the inpatient services of State-operated psychiatric hospitals that year. State and County Mental Hospitals, United States, 1982-83 and 1983-84, National Institute of Mental Health (Rockville, Maryland: 1986), DHHS Publication No. (ADM 86-1478), p. 3.

Studies show that from 22% to 36% of patients refuse medication at some point in their hospital stay. Applebaum and Gutheil, "Drug Refusal: A study of (Footnote continues on next page)

Washington Supreme Court's decision in Harper v. Washington will expose thousands of hospitalized and incar-

(Footnote continued from previous page)

psychiatric patients," 137 American Journal of Psychiatry 340-346 (1980), indicates 22%. Rodenhausér, "Treatment refusal in a forensic hospital," 12 Bulletin of American Academy of Psychiatry and Law 59-63 (1984), indicates 36%.

Refusals lasting more than 24 hours and requiring outside intervention to resolve average five percent. Hargreaves and Shumway, "The Jamison-Farabee consent decree: An attempt to protect the right of involuntary psychiatric patients to refuse medication." Presented at the Annual Meeting of the American Psychiatric Association, Dallas, Texas, May 1985; Appelbaum and Hoge, "Empirical Research on the Effects of Legal Policy on the Right to Refuse Treatment," in The Right to Refuse Anti-Psychotic Medication, American Bar Association, Commission on the Mentally Disabled (Washington, D.C.: 1986).

Assuming this 5% refusal rate, over 17,000 of the 343,744 state psychiatric patients nationwide are likely to refuse medication in a year, for a period of time necessitating intervention and review.

cerated individuals to the risk of harm or death each year. If the refusal rate of 5%⁷ remains steady, then 438 individuals who would have died of neuroleptic malignant syndrome over the next ten years have the potential of having their refusals upheld by judicial review, thereby avoiding the risk of needless death. Additionally, judicial review will have a broader effect, benefiting all patients. This is because the potential of outside review by the judiciary will curb dangerous practices without the necessity of the case ever reaching a court.

1. Features of neuroleptic malignant syndrome

Neuroleptic malignant syndrome is a potentially lethal patient response to

7. See footnote 6, supra at 12 and 13.

anti-psychotic or neuroleptic medication.⁸ It causes profuse sweating, severe muscular rigidity, hyperthermia, altered consciousness (mutism and stupor) and instability of the autonomic nervous system, including pallor, blood pressure instability and disturbance of heart rhythm. It also causes destruction of muscle tissue due to intense and sustained muscular contraction.⁹ Although first reported in the French psychiatric literature in 1960,¹⁰ and

8. See footnote 1, supra at 10.

9. Caroff, S.N., "The Neuroleptic Malignant Syndrome," 41 Journal of Clinical Psychiatry 79 (1980); Guze and Baxter, "Current Concepts: Neuroleptic Malignant Syndrome," 313 New England Journal of Medicine 163 (1985).

10. Delay, J., Pichot, P. and Lemperiere, T., "Un neuroleptique majeur non phénothiazine et non resérpinique l'halopéridol dans le traitement des psychoses," 118 Annales Médicin Psychologique 145-152 (1960).

described in isolated case reports in this country beginning in the 1960's,¹¹ as late as 1985 the leading authoritative textbook on psychopharmacology made no specific mention of neuroleptic malignant syndrome in its section on the toxic reactions and side effects seen with anti-psychotic medication.¹² One leading scholar has observed that "NMS is a neglected clinical problem of major proportions considering the large number of patients treated with neuroleptics."¹³ The potentially death-causing syndrome affects primarily young men, and occurs

11. Caroff, S.N., op. cit. at 79.

12. Baldessarini, R.J., "Drugs and the Treatment of Psychiatric Disorders." In Gilman, A.G., Goodman, L.S. and Gilman, A., eds. The Pharmacological Basis of Therapeutics 6th ed. (New York: Macmillan 1980).

13. Caroff, S.N., op. cit. at 79.

with high potency phenothiazines, the most common type of anti-psychotic medication.¹⁴

2. N.M.S. as a cause of two deaths in New Jersey, V.B. and D.W.

Amicus, as part of its responsibility as the designated Protection and Advocacy System for Mentally Ill Individuals in New Jersey,¹⁵ has conducted nine in-depth investigations of patient deaths in state

14. Guze and Baxter, op. cit. at 164.

15. The Protection and Advocacy for Mentally Ill Individuals Act of 1986, 42 U.S.C. sec. 10801 establishes a Protection and Advocacy System in each state with the authority and mandate to address abuse and neglect of mentally ill individuals in the State, including those who have died.

psychiatric hospitals.¹⁶ In September, 1988, its official, publicly-released report concluded that four young men, age 20 to 31, died needlessly, as a direct result of the improper administration and management of powerful psychoactive drugs prescribed and given to them by state hospital physicians.¹⁷ Two deaths resulted from neuroleptic malignant

16. Each investigation includes review of the entire medical record and autopsy report by an independent physician specialist, interviews with hospital staff and surviving family, review of toxicology reports, State Medical Examiner case analysis and hospital police department investigative file, if any.

17. Investigation Of The Circumstances Of The Deaths Of V.B., G.O., And D.W., Patients At Greystone Park Psychiatric Hospital And The Death Of S.A., A Patient At Marlboro Psychiatric Hospital (Department of the Public Advocate, Trenton, New Jersey: 1988) (The investigation of the deaths was conducted by William F. Culleton, Jr., Esq.) Available upon request.

syndrome, and two from hyperthermia, (described at p. 26, infra).

The death of V.B.

V.B., aged 25, was a patient at Greystone Park Psychiatric Hospital, a state-operated facility. On May 20, 1987, he smothered to death in his bed, face down in his pillow. The Morris County Medical Examiner found that V.B.'s neck and upper body muscles were so stiff from anti-psychotic medication that he could not turn his head to breathe. Amicus' report concluded that Greystone physicians repeatedly administered large doses of neuroleptic drugs to V.B. for about three months; yet, the drugs were ineffective in helping him. The Medical Examiner found that these drugs caused V.B. to develop neuroleptic malignant syndrome; however, the report of amicus showed that Greystone staff failed to

stop V.B.'s drugs and to treat him for NMS, as required by the accepted standard of medical care. Its investigation leads to the conclusion that V.B.'s Greystone psychiatrist erroneously assumed that V.B.'s squirming, restlessness, crawling and moaning were signs of mental illness, not symptoms of NMS.

The investigation further established that the hospital either recklessly and intentionally ignored V.B.'s susceptibility to NMS or, at a minimum, that the state hospital negligently ignored it. A social worker's note in his medical chart that V.B. had suffered an episode of NMS during a previous admission to a different hospital was buried deep in his medical record. No one highlighted or flagged the entry, or addressed it in any way. It does not appear on the first

page of the chart (known as the "Data Overview" Sheet) even though this form has a section specifically calling for information on "Allergies and Adverse Reaction." The information does not appear on any other summary sheet, including the physician's Admission Notes and the admitting psychiatrist's summary.

Despite 75 days on potent and high-dose neuroleptics, V.B.'s psychiatric condition deteriorated seriously. On February 22, 1987, a nurse noted that V.B. was banging his head against a wall. During March and April, 1987, nurses and doctors noted in V.B.'s ward chart that he repeatedly banged his head against walls, became more and more threatening and verbally aggressive, suffered a dizzy spell, and, on April 2 and 18, 1987, struck other persons.

By May 3, seventeen days before his death, V.B. began to exhibit extreme discomfort, "rocking" in chairs and "roll[ing] about restlessly" in bed, according to his doctor. On May 7, the doctor's notes in his ward chart describe him as restless, fearful, and unable to respond coherently to questioning.

Despite his knowledge of V.B.'s suffering during this period of time, V.B.'s psychiatrist repeatedly ordered staff to inject V.B. with "STAT" or immediate doses of neuroleptic medication, and, according to his own chart entries, he actually increased the dosage. The ward chart discloses no attempt to discover a physical cause for V.B.'s rocking, squirming and continuing restlessness. Another blood test was taken on May 7, but the ward chart does

not contain any comment on the results of this blood test.

By May 12, V.B.'s upper limbs were contracted and his lower limbs were extended, while he lay in bed, shaking. At night, he began moaning, and by the morning of May 13, his chart indicates that he was mumbling and sweating profusely. All of these are signs of NMS. On May 14, the doctor noted that V.B. presented a "fixed staring gaze," with dilated pupils and with his mouth hanging open; there was no response to external stimuli.

For the next five days, he lay stiff as a board on his stomach or his back, not moving. On May 20, he was found dead, smothered to death in his pillow.

The September, 1988 report by amicus documented the failure of hospital staff

to diagnose NMS even though the well-established clinical signs were evident for months, the failure to address his elevated CPK (creatine phosphokinase) blood levels that are a certain sign of muscle cell necrosis associated with NMS, failure to take daily blood tests when signs of NMS are evident, and failure to stop the neuroleptics after five months even though his condition progressively worsened.

The death of D.W.

V.B. was not the first patient known to have died at that same hospital of NMS. Four years earlier, 20 year old D.W. also smothered to death in his pillow from muscular stiffness brought on by the potent neuroleptic Haldol. The Morris County Medical Examiner attributed D.W.'s asphyxiation death to the hospital-administered Haldol. The 1988

investigative report by amicus established that state hospital officials never heeded the earlier warning from D.W.'s death and did not adjust by one iota their clinical practices or drug monitoring, so that V.B. was permitted to die from a virtually identical set of failures four years later.

The report showed that D.W.'s refusal of medication was overridden solely because he had been found in bed with a female patient the night before and that his grotesque muscle stiffness, incontinence, drooling and unsteady gait never led to a discontinuation of medication. He received it until he died. This case, like the case of V.B., reveals medication given for purposes of control not treatment, and demonstrates a perpetuation of medication despite worsening and dramatic physical consequences.

This case also illustrates the totally insufficient protection afforded refusing patients by a system of solely internal review. D.W. had no forum in which to argue that he was being force-medicated as punishment. (See generally Point II, infra at 36.)

3. Features of hyperthermia

Neuroleptic drugs, especially Thorazine, impair the body's ability to regulate its own temperature. Ordinarily, the body regulates its temperature by sweating and dilating peripheral blood vessels to dissipate heat. In cold environments, the body shivers to retain warmth. However, persons taking Thorazine become almost poikilothermic, like reptiles or other cold-blooded animals whose body temperatures vary at the mercy of the temperature of the air, ground or water

surrounding them.¹⁸ Thus, when the ambient environmental temperature exceeds 90 degrees, as it does in state hospitals in hot climates or in summer, patients on Thorazine are in danger of developing excessive body temperature, or hyperthermia, which can be fatal.

In addition to its other side effects, Cogentin, (prescribed to counteract side-effects) like Thorazine, interferes with the body's ability to regulate its own temperature, by preventing sweating and dilation of peripheral blood vessels for the dissipation of body heat. Especially in hot

18. Shalev, A., Hermesh, H., and Munitz, H., "The Role of External Heat Load in Triggering the Neuroleptic Malignant Syndrome," 145 American Journal of Psychiatry 110 (1988); American Psychiatric Association, Sudden Death in Psychiatric Patients: The Role of Neuroleptic Drugs (Washington, D.C.: 1987), p.19.

weather, the skin can become dry, hot and red, and the patient can develop a seriously high body temperature, which can cause heat stroke and death.¹⁹

4. Hyperthermia as a cause of
two deaths in New Jersey,
G.O. and S.A.

The same 1988 investigative report by amicus documented two patient deaths in state psychiatric hospitals as a direct result of hyperthermia, G.O. in 1985 and S.A. in 1983. Like the NMS deaths described above, hospital officials failed to alter their medication practices after S.A.'s untimely death so that G.O. was allowed to die of the same causes two years later.

19. Ibid.

The death of G.O.

G.O. aged 31, died at Greystone Hospital on August 14, 1985. According to the Medical Examiner, the cause of death was drug-induced hyperthermia (excessive body temperature) and acute pulmonary edema, (a swelling of the lung tissue) after G.O. inhaled his own vomit. Thorazine and Cogentin were the drugs identified by the Medical Examiner as causing death. The report by amicus described a sequence of errors, in which Greystone staff prescribed a combination of medications that led to G.O.'s untimely death. They locked G.O. into a non-air conditioned ward on a hot, humid August day; then they administered high doses of two drugs which, in combination, stripped his body of the ability to regulate its own temperature. In addition, these drugs induced G.O. to vomit and

then interfered with his body's natural coughing reflex, causing G.O. to inhale his own vomit. The report showed that neither drug had helped G.O. during a period of six months before his death, even though the dose of Thorazine was massive. His worsening condition (inert, weak) never led to blood tests or discontinuation of the medication.

The death of S.A.

On July 3, 1983, over two years before G.O. died, 22 year old S.A. also died of hyperthermia, as determined by the Monmouth County Medical Examiner. The report showed that S.A.'s death resulted from the administration of the drug Cogentin for nearly two months while he was an inpatient of the Marlboro Psychiatric Hospital, also a state-operated psychiatric hospital. On the

day of his death, Marlboro staff permitted S.A. to go out on a day pass, and failed to warn S.A. and his family that exposure to the heat of a summer day could kill him. S.A. died from hyperthermia after he accompanied his brother on an afternoon at the beach. Marlboro Psychiatric Hospital prescribed the potentially-dangerous drug Cogentin for side-effects of the Haldol, but S.A.'s record is devoid of any evidence of side-effects which would necessitate the Cogentin.

Thus, the "private interest" prong of the Mathews v. Eldridge, 424 U.S. supra, test is amply satisfied where, as here, state officials mindlessly prescribe potentially death-causing drugs without regard to the ineffectiveness of

those drugs, without regard to the worsening physical condition of their previously healthy patients and fail to stop the medication before they cause death.

If a patient who was force-medicated had available to him a judicial hearing, with counsel and the opportunity to present his own psychiatric witnesses who could describe the reckless administration of medication by state officials in that case, the likelihood of relief from a court would be substantial.

The existence of judicial review would not only afford refusing patients a realistic forum for obtaining relief, but would also heighten physician awareness and deter reckless prescribing practices without the necessity of those cases ever reaching a court.

- B. The risk of error where
judicial review is not
afforded is substantial

The four cases described above are evidence of a system in which hospital officials are the only individuals required to review medication refusals or patient care. D.W., who was force-medicated because he was found in bed with a female patient, never received the benefit of any external review. No judge ever evaluated his claim that he was entitled to be free of medication, that it was causing suffering and pain and that medication was administered as punishment.

D.W. was force-medicated after the Rennie v. Klein injunction was modified by the Third Circuit and while New Jersey

Administrative Bulletin 78-3, requiring solely internal review, was in effect.²⁰

Thus, hospital officials, based on the evidence of these four cases, cannot be entrusted to exercise the most basic professional judgment. Psychiatrists and clinicians have often themselves acknowledged their failure to recognize adverse effects of anti-psychotic medication.²¹ The desire for control of

20. See Point II, infra, for a discussion of the trial court's injunction in Rennie v. Klein and the modification of that injunction by the U.S. Court of Appeals for the Third Circuit.

21. See Crane, G., "The Prevention of Tardive Dyskinesia," 134 American Journal of Psychiatry 756 (1977) (describing the ineffectiveness of peer review committees, medical associations and physician education in altering the prescribing practices of physicians concerning neuroleptic drugs); Munetz, M., "Overcoming Resistance to talking to Patients about Tardive Dyskinesia," 36 Hospital and Community Psychiatry 283 (1985) (describing a study in a (Footnote continues on next page)

patients was paramount, and extinguished the initiation of efforts that could have saved these four lives. Critical self-regulation was utterly absent. Thus, the risk of error, the second factor analyzed

(Footnote continued from previous page)

Pittsburgh psychiatric hospital establishing that despite the adoption of strong informed consent protocols, physicians demonstrated "significant resistance to compliance with the informed consent guidelines"); Weiden, P., Mann, J., Haas, G., Mattson, M., and Frances, A., "Clinical Nonrecognition of Neuroleptic-Induced Movement Disorders: A Cautionary Study," 144 American Journal of Psychiatry 1148 (1987) (describing a study in which "high rates of physician non-recognition of all-major extrapyramidal syndromes, especially tardive dyskinesia, were found," despite abnormal hand movements and mouth movements); Brown., P. and Funk, S., "Tardive Dyskinesia: Barriers to the Professional Recognition of Iatrogenic Disease," 27 Journal of Health and Social Behavior 116 (1986) (describing "the patient's subordinate status,... professional dominance,...professional self-interest and overreliance on drug treatment" as causing "resistance to recognition of tardive dyskinesia."

by this Court in Mathews v. Eldridge, compels the conclusion that only judicial review would save helpless victims like V.B., D.W., G.O. and S.A. from hospital officials' reckless indifference to their plight.

II. IN NEW JERSEY AN INTERNAL
PEER REVIEW SYSTEM SIMILAR
TO THE SPECIAL OFFENDER
CENTER PROCEDURE IN HARPER
HAS PROVEN TO BE INEFFECTIVE
AND A DENIAL OF DUE PROCESS

The experience of New Jersey's state-operated psychiatric hospitals during the last ten years unmistakably demonstrates that a system of purely internal review of medication refusals fails to protect patients from the risk of harm caused by psychotropic drugs, and does not constitute the independent review of medication refusals which is required by the due process clause. That

system of internal review produced a mechanistic "rubber stamp" acquiescence of the treating physician's medication order.

New Jersey psychiatric hospitals have had experience with two different systems of overriding or respecting a patient's refusal of medication, one external and independent of the institution, and the other purely internal. The system of external review of medication refusals in New Jersey was that which was required by the trial court's injunction in Rennie v. Klein, 476 F. Supp. 1294 (D.N.J. 1979). That system required mandatory review by a psychiatrist who was independent of the hospital before a patient could be force-medicated. The other -- the result of the modification of that injunction by the Third Circuit -- left the decision of

whether to force-medicate a patient solely in the hands of the hospital medical director.

Amicus has provided legal and advocacy services to hundreds of patients under both of the systems, and has conducted a statistical analysis of the outcome data from these two systems. That data establishes that in 1980 when there was mandatory review of refusing patients by an independent psychiatrist, medication was discontinued or its dosage reduced in 59% of the cases. At the present time, with review left solely in the hands of the hospital's medical director, medication was discontinued or its dosage reduced in a mere 2.47% of the cases. Thus, the shift from an external system of independent psychiatric review to a system of internal peer review slashed the patient's likelihood of

having his medication discontinued or reduced by a factor of 2,400%.

Amicus has concluded from its statistical analysis, described more fully below, that internal review solely by the medical director is a wholly ineffective mechanism for protecting refusing patients from the risk of error and the risk of harm in violation of due process, Mathews v. Eldridge, 424 U.S. 319 (1976). (See Point I, supra.) Because the current New Jersey system is comparable to the Special Offender Center (S.O.C.), policy at issue in this case, the S.O.C. policy also violates due process and its invalidation must be upheld by this Court.

- A. The system of external review by an independent psychiatrist during the time that the trial court's injunction in Rennie v. Klein was in effect resulted in total discontinuation or

reduction of medication in
59% of the instances where
patients refused medication

Rennie v. Klein, 476 F. Supp. 1294
(1979)²² was one of the first cases in
the United States to determine the rights
of psychiatric patients to refuse psycho-
tropic medication. The district court
judge (Honorable Stanley S. Brotman)
found that side-effects of psychotropic
medication, including tardive dyskinesia,

22. Rennie v. Klein, 462 F. Supp. 1131
(D.N.J. 1978), 476 F. Supp. 1294 (D.N.J.
1979), modified and rem'd 653 F. 2d 836
(3d Cir. 1981) (en banc), vacated and
rem'd 458 U.S. 1119, 102 S.Ct. 3506
(1986), on remand 720 F. 2d 266 (3d Cir.
1983) (en banc).

For an analysis of the Rennie
litigation, see Brooks, "The Constitu-
tional Right to Refuse Antipsychotic
Medications," 8 Bull. Am. Acad.
Psychiatry and Law, 179 (1980), Brooks,
"The Right to Refuse Antipsychotic
Medications: Law and Policy," 39 Rutgers
Law Rev. 338 (1987), and Gelman, "Mental
Hospital Druggings - Atomistic and
Structural Remedies," 32 Clev. St. L.
Rev. 22 (1983-1984).

had not been diagnosed or treated, that hospital staff failed to follow administrative guidelines for side-effects, that medication decisions "...are often left to nurses or even attendants because doctors will ratify their recommendations without examining the patient..., " that there was overuse of medication and "...poor practices such as unjustified polypharmacy...." 476 F. Supp. at 1300. The court determined, after a careful review of the medical director's efforts to improve medication practices that review of medication refusals by medical directors was flawed because "...the medical director's actions demonstrate a lack of independence and objectivity when reviewing the actions of staff...." 476 F. Supp. at 1305.

The injunction which was issued, requiring review of medication refusals

by an independent psychiatrist, defined such person as a psychiatrist who was hired and paid by the Commissioner of the Department of Human Services, not otherwise employed by the Department or any of its hospitals, and who would be a neutral, independent decision-maker, 476 F. Supp. at 1308, 1313. The decree established informal hearings at which the independent psychiatrist would hear evidence and consider five factors in determining whether to uphold or override the patient's refusal:

(1) danger presented by the patient if not medicated

(2) the competency of the patient

(3) the patient's reasons for refusing

(4) whether the medication was being used to punish the patient, and

(5) a choice of medication that was least restrictive or least intrusive of patient autonomy. Rennie v. Klein, 462 F. Supp. 1131, 1146 (1978).

The federal district court required the defendant hospital officials to submit monthly reports on their progress in implementation of the injunction, 476 F. Supp. at 1315. These voluminous reports establish the number of medication refusal cases during the 12-month period from January 1980 through December 1980 while the injunction was in effect at the State's psychiatric hospitals.²³ New Jersey Division of Mental Health and Hospitals, "Monthly Reports on Patients

23. The injunction was in effect at all five state-operated adult psychiatric hospitals. The study conducted by amicus focused solely upon Ancora Psychiatric Hospital, which was the state hospital which was the main focus of the litigation.

Refusing Psychotropic Medications," January - December 1980, as filed with the United States District Court for the District of New Jersey.

Until now, no one has ever studied the data contained in the court-ordered monthly reports. In its empirical study, amicus reviewed each of the monthly reports submitted to the district court by the New Jersey Division of Mental Health and Hospitals. Amicus counted the number of refusal cases in which there was review by an independent psychiatrist, and the number in which medication was completely discontinued or its dosage reduced. That methodology establishes that there were 74 medication refusal cases reviewed by an independent psychiatrist, resulting in total discontinuance of medication in 10 cases and reduction of medication in another 34

cases, for a total of 44 cases in which medication was totally discontinued or its dosage reduced, or 59%.²⁴

- B. The system of internal peer review by hospital staff following modification by the Third Circuit of the trial court injunction resulted in total discontinuation or reduction of medication in only 2.47% of the instances where patients refused medication; this New Jersey system of internal review bears considerable similarity to the S.O.C. policy

In June of 1981, the Third Circuit Court of Appeals modified the district court's injunction, holding that New Jersey's Administrative Bulletin 78-3 met

24. Because the trial court injunction in Rennie prohibited force-medication of persons who had not yet had their initial commitment hearing, the 59% of persons afforded relief by the independent psychiatrist were persons who had already been determined by a court to meet the New Jersey standard for involuntary commitment, i.e. mentally ill and dangerous to self or others.

minimum constitutional standards. It was Administrative Bulletin 78-3 that was challenged by the Rennie plaintiffs, and invalidated by the trial court. It remains in effect to the present time, with only one significant modification. (See infra at 48). That Bulletin became the operative medication refusal policy following the en banc opinion of the Third Circuit. It requires review by the patient's treatment team and the hospital's medical director and allows for review by an independent psychiatrist but only if requested by the medical director. Rennie v. Klein, 653 F. 2d 836 (3d 1981) (en banc). The Bulletin, did not in 1981, and does not now, require state hospitals to obtain external review by an independent psychiatrist before force-medicating a patient. Bulletin 78-3, subsequent to the Third Circuit's

modification of the injunction, omitted protections afforded by patient advocates²⁵ and mandatory independent psychiatrists and used a lower standard for forced medication, whenever it was "...considered a necessary part of a patient's treatment plan." 653 F. 2d at 852. The Third Circuit holding was vacated and remanded by this Court for reconsideration in light of Youngberg v.

25. The Patient Advocate was a non-physician in the employ of the Department of Human Services, which operates the state psychiatric hospitals. The Patient Advocate, often referred to as a Rennie Advocate, had the responsibility of trying to persuade the patient's psychiatrist to adjust or discontinue the medication if the Rennie Advocate concluded that the circumstances so warranted. If those efforts were not successful, the Rennie Advocate had the authority to retain an independent psychiatrist whose determination -- while the injunction in Rennie was in effect -- was binding upon hospital officials. 476 F. Supp. 1311.

Romeo,²⁶ 458 U.S. 1119 (1982). On remand the Third Circuit again affirmed Administrative Bulletin 78-3, on slightly different grounds, 720 F. 2d (3d Cir. 1983) (en banc).

Administrative Bulletin 78-3 has remained in effect to the present time. The state has modified it from time to time, and has retained the element of the district court's injunction that required a patient advocate even though the Third Circuit did not require it. The mandatory independent psychiatrist reviews were abandoned by the defendants in 1981.

New Jersey Bulletin 78-3 and the S.O.C. procedure are similar in a number of important respects. Like 78-3, the S.O.C. procedure for reviewing medication refusals is internal to the institution.

26. Youngberg v. Romeo, 457 U.S. 307 (1982).

There is no mandatory outside review. 78-3 requires review by the treatment team and the hospital's medical director, while the S.O.C. review is conducted by a S.O.C. committee made up of a psychiatrist, a social worker and an Associate Superintendent with an appeal to the Superintendent. The standard under 78-3 of "...necessary part of a patient's treatment plan" is comparable to the S.O.C. standard of "gravely disabled." In both standards, the sole consideration is the patient's apparent need for medication. Neither policy addresses in any way other factors such as the patient's competence, the presence of side-effects, the degree of the patient's current dangerousness within the institution, if any, or any suitable alternatives to medication. Neither 78-3 nor the S.O.C. procedure permits assistance of counsel,

and both permit the assistance of a lay advocate or advisor. See New Jersey Bulletin 78-3, as reported in 453 F. 2d 836 (3 Cir.1981) and S.O.C. Policy, Pet. Appendix B-3.

The State of New Jersey continues to prepare monthly statistical reports on medication refusal reviews under Bulletin 78-3. At Ancora Psychiatric Hospital during the 12-month period from May 1988 through April 1989, there were 213 refusal reviews by the medical director and 515 by the patient advocate. Of these 728 reviews (many patients were reviewed more than once over the year's time), there were decisions to totally discontinue or reduce medication in only 18 cases, or 2.47% of the 728 refusal cases. Only five were reviewed by an independent psychiatrist with recommendations to reduce medication in two

cases and to confirm the original prescription in three cases.²⁷

Thus, of the 728 medication-refusal cases studied under the internal/peer review system, an aggregate total of only 20 cases resulted in a discontinuance (18) or reduction (2) of medication, or 2.47%. The 1980 and 1988-89 review results of 59% and 2.47% respectively show an outcome difference of dramatic proportions. The New Jersey experience shows that a refusing patient is 24 times more likely to achieve a discontinuation or reduction of medication when there is external review by an independent psychiatrist than he is when the review

27. New Jersey Division of Mental Health and Hospitals, "Monthly Service Report Service Statistics (medical director's report), "Monthly Statistical Report" (medication advocate's report) and "Medications Review Form" (independent psychiatrist's report) May 1988 through April 1989.

is solely internal. Mandatory external review has provided meaningful review with the real potential that objecting patients would be afforded significant relief. Conversely, internal review lacks that potential and constitutes a "rubber stamp" process disguised as independent review, thus denying due process of law.

One of the main components of due process is the right to an independent, neutral decision-maker. Parham v. J.R., 442 U.S. 585, 99 S.Ct. 2493, 2506 (1979). The dramatic difference in outcomes between 1980 and 1988-1989 in New Jersey demonstrates that independent professional judgment was not, and cannot be, exercised by institutional physicians. In 1980, as in 1988-1989, the refusal cases studied by amicus all involved decisions by psychiatrists. The sole

variable was whether the psychiatrist who served as decision-maker was employed by the facility (1988-1989) or whether he was an outside psychiatrist brought in for the purpose of reviewing the forced medication decision (1980, per the injunction). The fact that there was a 24-fold reduction in medication refusal outcomes when the review was solely by an internal psychiatrist leads inexorably to the conclusion that decisions by institutional psychiatrists are impermissibly tainted by such unlawful factors as staff convenience, lack of objectivity, unwillingness to diagnose and treat side-effects and by a tendency to see medication as a panacea to achieve institutional order.

Thus, the decision of the Washington Supreme Court in Harper v. Washington that prison officials are not

"independent professional decision makers...afford(ing) prisoners ample due process," 110 Wash. 2d 873, 880 (1988), 759 P. 2d 358, 363 (1988), is amply borne out by the New Jersey experience when the Rennie injunction was in effect and in the aftermath of its dissolution.

III. THE GOVERNMENTAL INTEREST
IS NOT UNDULY AFFECTED BY
JUDICIAL REVIEW OF
MEDICATION REFUSALS

One of the factors which must be considered in determining what process is due to psychiatric patients who refuse psychotropic medication is the "...governmental interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail," Mathews v. Eldridge, 424 U.S., supra, at 335. Judicial review of refusing patients

requires judicial and hospital staff time and to the extent that medication refusals are upheld more frequently by judges than by administrative officials, there may be a need to use other treatment modalities that may be more time-consuming or more costly than medication.

These results, however, do not stand in isolation, but must be weighed against the intrusiveness of forced medication, the risk of harm and the risk of error, Mathews v. Eldridge, 424 U.S., supra, at 334. (See Points I and II, supra.) "Due process is flexible and calls for such procedural protections as the particular situation demands." Morrissey v. Brewer, 408 U.S. 471, 481 (1972). In cases where the potential deprivation that may be created by the decision is great, additional due process protections are required, despite the fact that they are

more costly or adversely affect governmental functions, Goldberg v. Kelly, 397 U.S. 254 (1970).

In this case, the balance must be struck in favor of procedural protections that reduce the risks to patients to the lowest levels possible. Bodily invasion by the State, with the risks of death, disfiguring neurological impairment and painful side effects are extreme deprivations with few parallels in our jurisprudence. Such potential deprivations must be tested by an adversarial judicial process in which the patient's objections and the benefits and risks of medication are reviewed by an independent, neutral decision-maker. Only such a process will adequately protect the right to refuse psychotropic medication and reduce risks to patients to the minimum level possible.

Petitioner and its amici all vigorously argue that judicial review of inmates refusing medication will wreak havoc on an overburdened and underfunded state penal system. This argument ignores the fact that the same could be said of involuntary commitment hearings for civilly committed patients. Those judicial hearings likewise consume physician time that would have otherwise been spent in treating patients, yet 47 states require judicial review of civil commitment. Although judicial review of civil commitment is more expensive and time-consuming than an administrative review approach, not only do 47 states require it, but this is an increase from 40 states in 1970. Brakel, et al., The Mentally Disabled and the Law, at 72 (American Bar Foundation, 1985). Only Nebraska, South Dakota, and West Virginia

do not have judicial review of involuntary commitment. This almost universal public policy of requiring judicial review of civil commitment flows from a recognition that administrative commitment mechanisms, characterized by medical judgment and simplification of the commitment process, have been inadequate to the task of protecting personal liberty.

There should be a similar recognition in this case that administrative review of medication refusal is also inadequate to protect patients from the risks of psychotropic medication, a fortiori, since the result of civil commitment -- loss of liberty -- is reversible, while certain results of psychotropic drugs -- death or neurological damage -- are forever.

The effect of judicial review of medication refusals on the governmental function including administrative and fiscal burdens is not unduly burdensome. It is estimated that 5% of hospitalized psychiatric patients refuse psychotropic medications.²⁸ Assuming that the cost of judicial review of medication refusals is similar to the cost of judicial review of civil commitment, the effect on the governmental interest would be to add a 5% increment to a system of judicial review that is already in place in 47 states, to require three states to develop such a system, and to require all states to develop a system of judicial review of medication refusal in prisons. The implementation of such systems could be done in a similar fashion to those

28. See Point I, fn 6.

judicial procedures that exist for civil commitment, electro-convulsive therapy and guardianship. This is not an onerous burden for the states to meet.

In New Jersey, for example, judicial review of civil committees who refuse medication can be done at state hospitals by the same judge who reviews civil commitments. Prison inmates who are mentally ill and dangerous and who refuse medication in prison are typically transferred to a state hospital where they receive regular commitment hearings pursuant to N.J.S.A. 30:4-27.1 et seq., N.J.S.A. 30:4-27.22. Medication refusal hearings can, likewise, be conducted for this group without any significant

additional resources.²⁹

Past history in New Jersey clearly demonstrates that external review is neither burdensome nor costly. During the time that the preliminary injunction was in effect in Rennie v. Klein, 476 F. Supp., supra (See Point II, supra), when there was external review of medication refusals, the state defendants made no application to modify or dissolve the injunction because of any undue

29. New Jersey has approximately 10,000 public psychiatric hospital admissions each year, including commitment of state prisoners. If 5% (see Point I, supra, fn. 6) of those patients refuse medication, there would be 500 medication refusal hearings each year or 2 per month in each of New Jersey's 21 counties. These hearings could be conducted at each hospital at the time that civil commitment hearings are conducted, which is weekly or bi-weekly, with dockets ranging from 20-60. The court, the attorneys, and the hospital staff are present. Adding medication refusal cases to the civil commitment docket would not unduly affect any party.

effect on the functions of the hospital. The injunction was in effect for 18 months at five state hospitals. During 1980, there were 74 external reviews at Ancora, the hospital which was the principal target of the litigation. If the injunction had, in fact, been wreaking havoc on the state's psychiatric hospitals, then surely the defendants would have sought its dissolution. They did not do so. One commentator reported that rather than adversely affecting the governmental interest, outside review had benefited patients as well as the hospital and the public interest:

The administration of medication has significantly improved...there is much less medication being used... observers report fewer side effects. Nor have these improvements been accomplished at any significant cost to treatment values. In fact, treatment itself has improved. Brooks, "The Consti. right to

Refuse Antipsychotic Medications," Brooks, 8 Bull. Am. Acad. Psychiatry and Law 179, 213 (1980).

Thus, the governmental interest would not be unduly affected by judicial review of medication refusals because there is already a system in place for review of involuntary civil commitment, including civil commitment of inmates. The number of medication refusals reviewed by the judiciary would not increase the existing docket at state hospitals by more than 5% and would therefore constitute only a de minimus cost to state hospital systems. While the cost of judicial review is likely to be greater in some state correctional systems, it will never approximate the cost of judicial review of civil commitment, which has been widely practiced for more than a decade.

CONCLUSION

The standard for determining what process is due for mentally ill inmates who refuse anti-psychotic medication is established by Mathews v. Eldridge, supra. When the three-prong Mathews test is applied to this case, it is undeniable that the nature of the private interest includes avoiding the risk of death, that the risk of error is substantial because of the failure of state physicians to acknowledge life threatening, painful or disfiguring side effects and that the governmental interest in avoiding additional fiscal or administrative burdens is not unduly affected. Moreover, as the New Jersey experience under Rennie demonstrates, state hospital officials are unable to exercise independent professional judgment when they are the sole arbiters of medication refusal. For

these reasons, the decision of the Washington Supreme Court requiring judicial review should be affirmed by this Court.

Respectfully submitted,

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AMICUS CURIAE

BRIEF

JUN 29 1989

JOSEPH F. SPANIOL, JR.
CLERK

15
NO. 88-599

IN THE
Supreme Court of the United States
October Term, 1988

STATE OF WASHINGTON, et al.,

Petitioners,

v.

WALTER HARPER,

Respondent

ON WRIT OF CERTIORARI
TO THE SUPREME COURT OF THE STATE OF WASHINGTON

BRIEF AMICUS CURIAE OF THE COALITION FOR
THE FUNDAMENTAL RIGHTS AND EQUALITY OF
EX-PATIENTS IN SUPPORT OF RESPONDENT

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I. STATEMENT OF INTEREST OF AMICUS CURIAE

This brief *amicus curiae* is being filed in support of respondent and his "right to refuse" unwanted and potentially dangerous psychotropic drugs. Counsel for the petitioner and respondent have consented to this brief. Their consents will be filed with this Court.

Amicus curiae, the organizational members of the Coalition for the Fundamental Rights and Equality of Ex-Patients¹ (hereinafter the "Coalition for the FREE") are all groups whose primary interests and activities concern the promotion of public understanding of mental health issues and the protection of the rights of the mentally ill and of present and former mental patients. Members and clients of these organizations include many former patients, their families and friends, as well as advocates for the mentally ill.

¹ The participants in the Coalition for the FREE are as follows:

NATIONAL MENTAL HEALTH ASSOCIATION

The National Mental Health Association ("NMHA") is the nation's oldest and largest non-governmental, citizens' voluntary organization concerned with mental illnesses and mental health. Founded in 1909 by Clifford Beers, a man who suffered from a serious mental illness, the Association has historically led efforts on behalf of mentally ill people in institutions and the community. The NMHA has grown into a network of 650 chapters and state divisions working across the United States. It is composed of volunteers who are mostly non-mental health professionals. Some are family members whose loved ones have been affected by mental illness; others are former patients. All are committed to advocacy for the improved care and treatment of mentally ill people, the promotion of mental health and the prevention of mental illnesses.

NATIONAL MENTAL HEALTH CONSUMERS' ASSOCIATION

The National Mental Health Consumers' Association was organized in Baltimore, Maryland in June, 1985, as a national representative voice for mental health consumers and charged with developing national forums so that the concerns of mental health consumers can be heard, on issues such as the right to refuse psychotropic drugging.

THE MENTAL HEALTH CONSUMERS' NATIONAL LEGAL DEFENSE AND EDUCATION PROJECT

The Mental Health Consumers' National Legal Defense and Education Project was organized by consumers in Philadelphia, Pennsylvania in 1988 to provide technical assistance, research and training to mental health consumers and their advocates on legal and policy issues involving mental illness and consumers' rights and to assist consumers with access to the courts,

The Coalition for the FREE has appeared as *amicus* before the courts in numerous cases involving the rights of persons with mental illness, including cases involving forced drugging.² The issue of forced psychotropic drugging in any setting is a primary concern of the Coalition and its members because of their own experiences with the painful and disabling side effects from any use of these drugs and because of the violations of personal rights and autonomy involved in their involuntary administration. As reflected in this brief, these organizations of mental patients and their advocates condemn the forced drugging of persons committed to mental hospitals or in correctional facilities absent true emergencies and support their right to

legislatures and agencies on matters affecting their lives as consumers of mental health services.

THE MENTAL PATIENT'S ASSOCIATION OF NEW JERSEY

The Mental Patient's Association of New Jersey was established in May, 1984 in Asbury Park, New Jersey and is a statewide network of individuals and self-help organizations devoted to the development of self-help and advocacy groups and the protection of the interests and rights of mental health consumers.

THE MENTAL PATIENTS' ASSOCIATION OF PHILADELPHIA

The Association was formed in Philadelphia in 1985 in an effort to organize mental health consumers to oppose all efforts to erode the rights and freedoms of those who have been hospitalized for psychiatric illness and to call for an end to discrimination against the psychiatrically disabled in any form.

² See, e.g. the briefs *amicus curiae* filed by the Coalition in *United States Department of the Treasury, Bureau of Alcohol, Tobacco and Firearms v. Galito*, U.S. , 106 S. Ct. 2683, 91 L. Ed. 2d 459 (1986) and *Colorado v. Connelly*, 497 U.S. 157, 107 S. Ct. 1551 (1986). See also, the Brief of the Office of the Capital Collateral Representative, *et. al.*, as *amicus curiae* in *Ford v. Wainwright*, 477 U.S. 399, 106 S. Ct. 2595, 91 L. Ed. 2d 335, (1986) and the proposed brief *amicus curiae* of the Coalition in *Satterwhite v. Texas*, U.S. , 108 S. Ct. 1792, (1988). The Coalition has also filed or participated in *amici* briefs in state court cases across the United States involving the "right to refuse" forced drugging: *Riese v. St. Mary's Hospital and Medical Center*, 196 Cal. App. 3d 1388, 243 Cal. Rptr. 241 (1987), *Jones v. Gerhardstein*, 141 Wis. 2d 710, 416 N.W. 2d 883, (1987) and *Application of Anonymous* ("Billie Boggs"), N.Y. Court of Appeals, No. 95565/87. See also, Barbanel, "Joyce Brown Panhandled Again", N.Y. Times, Mar. 9, 1988, p. B3: ("A State Supreme Court judge ordered her release, but the Appellate Division overturned the decision. City doctors agreed to release her after they were barred from giving her medication against her will.")

refuse these dangerous drugs.

This Coalition of mental patients' groups -- and their allied advocacy organizations -- have endorsed the concept of *judicial* review of mental patients' competency to make their own decisions to refuse these drugs. To the extent that limited medical or state hospital administrator reviews have been utilized, ^{2A} the patients' "right to refuse" has proven to be illusory and unworkable. Because of their concern that many mental patients and others such as respondent here continue to be at great risk from having these painful and dangerous drugs forcibly injected into them, the members of the Coalition wish to share their experience and views on these matters with the Court in this precedent-setting case which will affect the future of forced drugging of prisoners in Washington State and, quite possibly, across the rest of the United States. *Amicus* believes that no other party or *amicus* will present the perspectives of mental health consumers to the Court in this case and, for the reasons stated above, respectfully submits this Brief.

^{2A} See, e.g., *Rennie v. Klein*, 462 F. Supp. 1131 (D. N.J. 1978), *suppl.* 476 Supp. 1294, (D. N.J. 1979), *modified in part* 653 F. 2d 836 (3rd Cir. 1981), (en banc), *vacated and remanded* 458 U.S. 1119 (1982), *on remand*, 720 F. 2d 266 (3rd Cir. 1983) (en banc). See also, Brooks, "Law and Antipsychotic Medication", 4 *Beh. Sci. & the Law* 247 at 260 (1986) (regarding the New Jersey Administrative Bulletin 78-3 "right to refuse" procedure as a mere "paper procedure").

II. SUMMARY OF ARGUMENT

The recent enactment of a Washington State "right to refuse" statute by the Washington legislature has changed the nature of the questions presented here so markedly that this Court should either (1) dismiss the writ in this case as improvidently granted or (2) amend or narrowly construe the questions presented so as to focus *only* on the prisoner's right to refuse and the process due him in exercising that right. Part III A.

Because the respondent prisoner has never been found incompetent for any purpose by a court of law, he retains the same "right to refuse" as a competent but involuntarily committed mental patient. Part III B.

The *Turner v. Safly* "reasonable relation" test of prison regulations does not apply to the absolute prohibition of a prisoner's fundamental right to bodily integrity and privacy as it relates to his right to refuse dangerous psychotropic drugging. The better standard is the test adopted by the dissent in *O'Lone v. Shabazz* regarding heightened scrutiny of prison regulations prohibiting exercise of fundamental rights. In the alternative, if the "reasonable relation" standard *does* apply, the SOG regulations here fail even that deferential standard. Part III C.

Based on the current research studies of drugging side effects, the Washington Supreme Court was correct in its assessment of the potential damage of those side effects on persons such as respondent. These disabling, disfiguring -- and potentially even lethal -- side-effects justify the *Harper* court's mandate of a judicially overseen right to refuse procedure for respondent and other prisoners. Part III D.

The "right to refuse" procedures in other states with external review procedures -- including judicial oversight -- are both necessary and cost-effective. The studies and documented experiences in "right to refuse" states across the country regarding drug refusals demonstrate that appeals are only part of the total process of drug refusals. Rather than causing judicial or fiscal chaos, the right to refuse has in fact resulted in improved treatment procedures and therapeutic alliances between professionals and patients. Part III E.

III. ARGUMENT

A. Because Of The Enactment Of A Broad "Right To Refuse" Statute By The Washington State Legislature After The Grant Of Certiorari In This Case, The Writ Should Be Dismissed As Improvidently Granted Or, In The Alternative, The Questions Presented Should Be Amended Or Narrowly Construed.

On April 20, 1989, over one month *after* certiorari was granted in this case, the Washington Legislature enacted its own "right to refuse" statute. See Substitute Senate Bill No. 5362, Chapter 120, Washington Laws of 1989, lodged herewith as "Appendix A".³ In brief, that statute now provides for a "right to refuse" for all of that state's civilly committed mental patients while specifically excluding prisoners. Quite apart from the equal protection, due process, Eighth Amendment and other issues raised by this new law, *amicus* believe that the new statute significantly changes this case.

In its decision below in this case, the Supreme Court of the State of Washington relied upon constitutional law as the basis for its finding that prisoners such as respondent were entitled to the "right to refuse", and that judicial review was required for any exercise of state authority to override that right.

In *Schuoler*, we held that the statutory protection afforded by the involuntary treatment act was inadequate to protect the independently existing constitutional right to refuse ECT. Here, we extend our analysis in *Schuoler* to recognize a right to refuse antipsychotic drug treatment. We do so on constitutional *rather than on statutory grounds*. Moreover, we conclude that the *constitutional* liberty interest in refusing ECT and antipsychotic drug treatment survives criminal conviction just as it survives *civil involuntary committment*. *Harper*, 110 Wn. 2d above at 881-2 (emphasis added).

³ The existence of that act is just barely acknowledged once in Pet. Brief, p. 4 n. 3 and once in the Brief of the United States as *amicus curae*, at p. 11 n. 20.

Clearly, the enactment of a statewide legislative "right to refuse" provides a new, and quite independent state law basis for any future judicial review of any related claim whether from a patient or a prisoner. Assuming that such a statute had been in effect during Harper's state court proceedings, the whole nature of this case would necessarily have been different. Rather than relying on the constitutional law justification from state court decisions in the first instance, as well as on federal case law, the state Supreme Court's opinion in this case would surely first have focused on the legislature's reasoning and its approach to ensuring the "right to refuse" in the broad context of civil commitment.

Thus, in light of the new state law, for this Court to consider the "Questions Presented" as currently stated -- especially given the issue of the unprecedented extension of *Turner v. Safly* into this area (see Part III C below) -- seems an inefficient and unproductive use of its judicial resources. The simplest expedient, given this change in the legal setting of this case, is for the Court to dismiss the instant writ of certiorari as improvidently granted. There is ample precedent in the Court's caselaw for just such dismissal. See, e.g., *Sanks v. Georgia*, 401 U.S. 144, 91 S. Ct. 593 (1971); *Cook v. Hudson*, 429 U.S. 165, (1976).

Moreover, in keeping with this Court's stated deference to decisions of state courts and state legislatures, review of the state Supreme Court's holding in this case seems particularly inappropriate now that the Washington state legislature has actually confirmed the broad principle of the "right to refuse".⁴

Indeed, in the one other "right to refuse" case heard by this Court, *Mills v. Rogers*, 457 U.S. 291 (1982), a similar motion and argument were made by the respondent patients. See *Mills v. Rogers*, 454 U.S. 936, 102 S. Ct. 471 (1981) (Respondent's Motion to Dismiss Writ or in the Alternative Certify Certain Questions to the Supreme Judicial Court of Massachusetts, denied.)

⁴ Compare Substitute Senate Bill No. 5362 with 43A Okla. Stat. Ann., § 4.8 (West's 1980) enacted by the Oklahoma Legislature after the early "right to refuse" decision *In re K.K.B.*, 609 P. 2d 747 (1980).

That motion, while denied before oral argument, put before this Court the very issue upon which the final decision in that case ultimately turned: an intervening "right to refuse" decision by the Massachusetts Supreme Judicial Court. See, *In the Matter of Guardianship of Richard Roe, III*, 383 Mass. 415, 421 N.E. 2d 40 (1981). In *Rogers*, both petitioners and respondents and their supporting *amici* were all finally in agreement -- albeit for far different reasons -- that the federal courts should defer to state courts and state institutions before imposing federal solutions to the complexities of mental health treatment issues there -- as here -- inextricably bound up with that state's law and legal traditions. See, e.g., *Mills vs. Rogers*, 457 U.S., above, Pet. Brief, p. 17 ("...(T)he First Circuit's remand to design creative procedures ... violated the doctrine of federalism ..."); Brief of the American Psychiatric Association ("APA") as *amicus curiae*, p. 27 ("... (T)he state must be able to treat illness that is the basis of commitment itself. The decision below is an unwarranted interference with that legitimate interest.")

Here, based in part on its own state laws and decisions, the Washington Supreme Court reasoned its way to a "right to refuse" and a judicial review procedure that applied to all civil committees and, thus, *a fortiori*, to respondent. Now the state legislature has codified its own state high court's "right to refuse" decision. Given this new independent "state law" basis in that state legislature's affirmation of its own state court decision, this Court should dismiss this writ. In the alternative, at the very least, this Court, acting with notice of the intervening state legislative action as to *all* other prospective recipients of forced treatment, should now amend or more narrowly construe the "Questions Presented" to limit its review strictly to the constitutionally-based "right to refuse" in the limited factual context of prisoners such as respondent. By virtue of the Washington State legislature's action, the broad question of the applicability of the constitutional "right to refuse" to civilly committed mental patients should not even be considered by this Court in its analysis of the basis for the "right to refuse" extended to Harper. In place of the Washington Supreme Court's reliance on state and federal constitutional caselaw *inter*

alia this case should be viewed as one limited to the extension of the now statutorily based "right to refuse" to prisoners and of the applicability of *Turner v. Safly* "reasonable relation" standard *vel non*. The underlying issue of the constitutional "right to refuse" for civilly committed patients has been definitively resolved by the Washington Legislature.

B. Respondent Prisoner Has the Constitutional Right to Refuse Unwanted Psychotropic Drugging.

Simply stated, the real issue in this case is not whether respondent prisoner has the right to refuse unwanted drugging⁵ but, rather, what process is due him regarding his exercise of that right. From the beginning of the state law based "right to refuse" in *Rogers v. Commissioner*, 390 Mass. 489, 458 N.E. 2d 308 (1983), the argument has been that persons neither civilly committed *nor* adjudicated incompetent retained their "right to refuse" state attempts at forced drugging. See, for a recent holding on this point, *In re Orr*, 175 Ill. App. 3d 498, 531 N.E. 2d 64 (1988). Clearly, as the Washington Supreme Court noted, if commitment alone does not abridge that right, then *a fortiori*, a criminal conviction and incarceration alone cannot abridge a person's right to refuse.

The problem for prisoners has been that the right to refuse attaching to their distinct status did not attract the same degree of either judicial or academic attention as did the right to refuse of involuntary mental patients⁶. As Professor Michael L. Perlin has recently noted, regarding the right in the related context of pre-trial detainees, "separate streams" of thought seem to have developed in the emerging law in this area regarding civilly

⁵ For the purpose of this Brief, we have elected to use the terms "psychotropic drugs" or "drugging" to refer to the use of the substances identified in *Harper*, 110 Wn. 2d above at p. 876, n. 3. All references to these drugs in this Brief use those generally accepted terms among consumers.

⁶ The two leading right to refuse cases involving prisoners are *Large v. Superior Court*, 148 Ariz. 229, 714 P. 2d 406 (1986) and *Lappe v. Loeffenholtz*, 815 F. 2d 1173 (8th Cir. 1987). See, for an article raising the issue of prisoners' right to refuse and suggesting treatment "negotiations": Smith, "Prison Psychiatry and Professional Responsibility", 32 *Jour. of Forensic Sci.* 717, at 721 (1987):

committed patients and those in the criminal justice system⁷. See Perlin, "Does Competency Matter After *United States v. Charters*?" Paper prepared for U. of Va. Institute of Law, Psychiatry and Public Policy, 12th Symposium on Mental Health and the Law, March 12, 1988, Williamsburg, VA. One possible explanation for this separate treatment of patients and prisoners may be found in Judge Weis' opinions in *Rennie*:

Presumptions of the institution's right to force medications to prevent dangerousness and to preserve institutional safety and discipline tend to preempt the patient's right to refuse medications and further delimit the scope and quality of treatment. It should be apparent that this model for the use of psychotropic drugs intensifies adversarial elements in the physician/patient relationship, and can only be detrimental to care programs. It seems to me that the ultimate answer to this dilemma is to involve more skilled and sensitive clinicians in the care of these deprived populations to raise the level of the professional competence and responsibility in the delivery of these health services. The numbers of confrontations which lead to court intervention could be reduced by employing more skilled clinicians who are sensitive to their patients' concerns and needs, and who are flexible and *and in a mood to negotiate with their patients*. (emphasis added)

Dr. Smith thereby indicates his endorsement of the typical "negotiation" outcome of the right to refuse. See Part III E below.

⁷ One earlier "crossover" case, *Vitek v. Jones*, 445 U.S. 480, 100 S. Ct. 1254, 63 L. Ed. 2d 552 (1980) clearly prefigured *Harper*. There the issue was the process due before a prisoner could be transferred to a state hospital where drugging could be presumed to occur. See *Vitek* 445 U.S. at 493-4:

A criminal conviction and sentence of imprisonment extinguish an individual's right to freedom from confinement for the term of his sentence, but they do not authorize the State to classify him as mentally ill and to *subject him to involuntary psychiatric treatment* without affording him additional due process protection. (emphasis added)

While *Vitek* was decided two years before *Mills v. Rogers* and *Rennie v. Klein* reached this Court, the briefs and the transcript of the oral argument before this Court in *Vitek* demonstrate that forced drugging was a subtext in that case. See, e.g., Brief of Appellee, Larry D. Jones, p. 7 ("when such transfer will submit him to chemotherapy"); p. 16 ("Once transferred he was forced to take Thorazine, his prescribed medication. When he refused, he was injected with the medication..."); p. 20 (regarding "the common use of chemotherapy in mental hospitals" as a danger to transferred prisoners); and Transcript of Oral Argument, Dec. 5, 1979, pp. 19-20 (prisoner's "right to refuse" medical treatments).

It is worth remembering that patients at these mental institutions are unwilling wards of the state. They have done nothing to merit anything but consideration and compassion. *Rennie*, 720 F. 2d above at 277 (Weis, J. concurring)

Compare the foregoing with Judge Weis' earlier remarks for the majority of the court on the relative rights of patients as contrasted to prisoners in the context of the Eighth Amendment issue, *Rennie*, 653 F. 2d above at 844. With the first, and then the second, appellate decision in the *Charters* case, the criminal justice stream of "right to refuse" cases have now entered -- or reentered -- the mainstream of "right to refuse" caselaw⁸. See *Charters v. United States* 829 F. 2d 479 (4th Cir. 1987) (hereinafter referred to as "Charters I"), *rev'd en banc* 863 F. 2d 302 (4th Cir. 1988) ("Charters II") *petition for cert. filed*, (February 6, 1989) (No. 88-6525) *mandate stayed* No. A-628, 57 U. S. L. W. 3545 (Brennan, J., Feb. 14, 1989). While *Charters I* had followed the logic of the *Rennie/Rogers* paradigm, *Charters II* held that, in the context of a pre-trial detainee, the "incompetency to stand trial" finding sufficed to overcome any existing "right to refuse" adhering to an adult otherwise legally presumed to be competent for making treatment decisions. See *Charters II*, 863 F. 2d above at 306:

Consequently, the current limitation on his basic liberty interest is constitutionally acceptable and his retained interest in freedom from bodily intrusion must yield to the legitimate incidents of his institutionalization.

The single "Question Presented" in *Charters*' pending Petition for *Certiorari* before this Court succinctly states the issue which distinguishes his case from that of respondent here:

Are the due process rights of a pretrial detainee in a criminal case, adjudicated incompetent to stand trial, *but not adjudicated mentally incompetent*, violated when he is

⁸ Another earlier case upholding a pre-trial detainee's right to refuse prefigured *Charters*. See *Bee v. Graves*, 744 F. 2d 1387 (10th Cir. 1984): *pet. for cert. denied*, 469 U. S. 1214, 105 S. Ct. 1187, 84 L. Ed. 2d 334 (1985). In that case the order for forced drugging originated at a hearing where the detainee was actually found *competent* to stand trial. See *Bee*, 744 F. 2d above, at 1389.

forced to undergo medication with anti-psychotic drugs, against his will and without a judicial determination that he is medically incompetent? *Charters v. United States*, petition for cert., filed (February 6, 1989) (No. 88-6525). (emphasis added)

The merits of *Charters II* aside, here there was no judicial finding of any incompetency for any purpose. Thus, even if *Charters II* is ultimately affirmed or if *certiorari* is simply denied, *Harper* is not *Charters II*; perhaps the best that can be said is that *Harper* is *Charters I* or *Large v. Superior Court*, above, with regard to respondent's presumed competency and his continuing constitutional right to refuse absent some additional judicial process. Moreover, as a convicted prisoner rather than a pre-trial detainee, *Harper* is not subject to the additional factor of the claimed need for the government to bring him to trial as argued in *Charters I* and *II*⁹. Here, clearly, any current governmental interest in safety and security (see Pet. Brief, p. 29) can be met by *alternative* means in the prison and, ultimately by transfer or commitment to a mental hospital *after* his sentence.

⁹ In addition to their differing views of the relevance of a judicial finding of incompetency, the two *Charters* opinions have diametrically opposed views of the relevance of the *Youngberg v. Romeo* "professional judgement" standard. *Youngberg v. Romeo*, 457 U.S. 305, 102 S. Ct. 2452, 73 L. Ed. 2d 28 (1982). While the *Charters I* panel held that the *Romeo* standard was not controlling -- following in this regard *Jarvis v. Levine*, 418 N.W. 2d above, at 147 and *Jones v. Gerhartstein*, 416 N.W. 2d above at 896 -- the *en banc Charters II* opinion endorsed the *Romeo* "professional judgement" criterion. Compare *Charters I*, 829 F. 2d above at 487-490 with *Charters II*, 863 F. 2d above at 312-313. Because neither *Romeo* nor *Rennie* addressed the competency issue in the context of drugging, the *Romeo* standard does not seem any more applicable here than in *Rogers* which *did* address competency in the context of drugging. It is particularly telling that *Rennie* was remanded by this Court in light of *Romeo*, while *Rogers* was remanded for proceedings in light of Massachusetts state law. See Point III A above.

C. Because of the Drugs' Potentially Irreversible -- Even Lethal -- Side Effects, the "Reasonable Relation" Standard of *Turner vs. Safly* is Insufficient to Permit Forced Drugging, Therefore, the State Must Prove a Clear, Cogent and Convincing Need to Forcibly Drug Prisoners.

Relying principally on *Turner v. Safly*, U.S. , 107 S. Ct. 2254, 96 L. Ed. 2d 64 (1987) as well as *O'Lone v. Estate of Shabazz*, U.S. , 107 S. Ct. 2400, 96 L. Ed. 2d 282 (1987), *Kent v. Johnson*, 821 F. 2d 1220 (6th Cir. 1987), and *Michenfelder v. Sumner*, 860 F. 2d 328 (9th Cir. 1987), the State argues that the "reasonable relation" test replaces the ordinary standards for Due Process analysis for the purpose of protecting prisoners from arbitrary governmental action. Compare *Harper*, 110 Wn. 2d above, at 833 with Pet. Brief, p. 15, n.10.

Finally, the State argues that the minimal protections offered by the Special Offender Center (hereinafter referred to as "SOC") policy satisfy the Due Process clause. The first -- and most fundamental -- flaw in this novel chain of reasoning is the one noted by Justice Brennan in his dissent in *O'Lone v. Shabazz*, U.S. , 107 S. Ct. 2400 (1987) regarding the propriety of using "reasonableness" as a standard to insure that "fundamental" restraints on government powers are enforced:

In my view, adoption of "reasonableness" as a standard of review for all constitutional challenges by inmates is inadequate to this task. Such a standard is categorically deferential, and does not discriminate among degrees of deprivation ...

It is true that the degree of deprivation is one of the factors in the Court's reasonableness determination. This by itself does not make the standard of review appropriate, however. If it did, we would need but a single standard for examining all constitutional claims, as long as every relevant factor were considered under this rubric. Clearly we have never followed such an approach. *O'Lone*, 107 S.

Ct. above, at 2408 (Brennan, J. dissenting)

Instead of the single, all purpose "reasonableness" standard, the four dissenting Justices in *O'Lone* adopted Judge Kaufmann's test of prison regulations from *Abdul Wali v. Coughlin*, 754 F 2nd 1015 (2nd Cir. 1985) which "maintains that the degree of scrutiny of prison regulations should depend on the nature of the right being asserted by prisoners, the type of activity in which they seek to engage, and whether the challenged restriction works a total deprivation (as opposed to mere limitation) on the exercise of the right". *O'Lone*, 107 S. Ct. above, at 2409, (Brennan, J. dissenting).

Here the right being asserted by the respondent prisoner could scarcely be more fundamental: the right to his bodily integrity, personal security and privacy. This Court has recognized the nature of this right in this context of drugging and other intrusive procedures. See, e.g., *Mills v. Rogers*, 457 U.S. above at 299. For his part, the "activity" sought to be conducted by the prisoner here is to continue to live in a condition free of these drugs and the very real risks of their potentially harmful and debilitating -- possibly even fatal -- side effects^{9A}. See Part III D below regarding these risks. The challenged prison restriction here is in fact the threatened *total* override under the SOC process of the *prisoner's* "right to refuse" these unwanted drugs and thereby avoid the risk of possible irreversible side effects. Like the *O'Lone's* dissent's view of the *totally* restricted Moslem religious ceremonies, here there is no "half-way" point on the issue of the prisoner's right to refuse forced drugging, *vel non*.

^{9A} Notwithstanding the claims of the State and its supporting amici about the benefits of these drugs, (See Pet. Brief, p. 21 APA Brief, p. 11 and Washington Community Mental Health Council, et al, ("CMHC") Brief, p. 13) even the basic effectiveness of the drugs is itself still subject to continuing debate. See, for a concise statement of these issues in the context of commentary on a decision (*Dautremont v. Broadlawns Hosp.*, 827 F. 2d 291 (8th Cir. 1987) which denied claims based on the "right to refuse" and instead applied the *Romeo* "professional judgement" standard, Cichon, "The Eighth Circuit and Professional Judgement: Retrenchment of the Constitutional Right to Refuse Antipsychotic Medication", 22 *Creighton L. Rev.*, at ns. 18-27, (1988-89) (in press):

Indeed, the lack of any real alternative to drugging is the very heart of the problem with the SOC procedures: it is all or nothing with no room for the treatment negotiations that have come to characterize "right to refuse" processes everywhere. See Part III E below. Even a small amount of forced drugging entails some risk. See Part III D below.

Applying the *O'Lone - Abdul Wali* approach to these facts, then, is a parallel to heightened scrutiny in the traditional due process model from *Matthews v. Eldridge*, 424 U.S. 319, 96 S. Ct. 893 (1976).

The *Abdul - Wali* approach takes seriously the Constitutional function of requiring that official power be called to account when it completely deprives a person of a right that society regards as basic. In this limited number of cases, it would require more than a demonstration of "reasonableness" to justify such infringement. To the extent that a prison is meant to inculcate a respect for social and legal norms, a requirement that prison officials *persuasively demonstrate* the need for the absolute deprivation of inmate rights is consistent with that end. *O'Lone*, 107 S. Ct. above at 2409-10. (emphasis added)

While it is indisputable that antipsychotic drugs are of great benefit to many psychotic patients, claims of their overall efficacy are subject to dispute. After over three decades of use, there is still not a widely agreed upon theory of the biochemical manner in which antipsychotics work. Indeed, there is not even a universally accepted theory on the cause of schizophrenia, the disorder the drugs are most effective in controlling. The medication does not cure psychoses; it merely suppresses many of its symptoms. The drugs are effective only while in the patient's bloodstream, with relapse often occurring once drug therapy is terminated. Not all patients benefit from antipsychotic drugs, and there is evidence that some individuals actually deteriorate when placed on medication. For those patients who do benefit, the extent of their improvement is subject to debate.

Complicating the matter is the fact that schizophrenia is often difficult to diagnose. Studies indicate that the misdiagnosis rate may be as high as forty percent. This statistic suggests that antipsychotic drugs are inappropriately prescribed in a number of cases. Even when the mental disorder is accurately diagnosed, there is not yet a scientifically sound method to determine the most appropriate antipsychotic drug to prescribe. Once a drug is selected, its proper dosage can only be determined on a trial and error basis. (references omitted)

By failing to provide for counsel, evidentiary rules, review procedures or protections against conflicts of interest, the SOC regulations clearly cannot withstand this higher level of scrutiny, as the Washington Supreme Court correctly found. See *Harper*, 110 Wn. 2d above at 884. See also Substitute Senate Bill No. 5362, attached hereto as Appendix "A". The SOC procedures fail of their own weight to satisfy the *O'Lone - Abdul Wali* test because they require only a committee majority vote without setting any requisite standard of proof for the professional's judgement to carry the day before the committee.

Finally, should this Court reject the *O'Lone - Abdul Wali* test, the SOC procedure fails the "reasonable relation" standard because of this last issue as well. Assuming *arguendo*, that the *Turner v. Saflly* "reasonable relation" test does in fact apply to all prison regulations, the SOC procedures also fail to satisfy even this minimal standard by providing for no alternative to drugging. The critical issue for "reasonable relation" test is, again, the *absolute* nature of the restriction on prisoners' right to refuse any unwanted drugging. There appears to be no doubt that the fully enforced SOC procedures admit of no exception such as the alleged availability of other religious services in *O'Lone*, the possibility of at least some acceptable visitors in *Kentucky Department of Corrections v. Thompson* U.S. , 57 U.S.L.W. 4531 (U.S. May 15, 1989) or the access to other "outside" permissible publications in *Thornburgh v. Abbott*, U.S. , 57 U.S.L.W. 4517 (U.S. May 16, 1989).

The State has clearly rejected seclusion, restraint or even transfer to another facility as alternatives to protect prisoners and staff. Even by the standard proposed by the State, the SOC procedures result in a *total* negation of the prisoners' right to refuse and, therefore, cannot be permitted to stand under the *Turner vs. Saflly* standard. By completely overriding the prisoners' right to refuse with *no* alternative, the SOC procedures are an "exaggerated response" to the drugging issue. See *Turner*, 107 S. Ct. above at 2266-7 (regarding "the almost complete ban on prison marriages"). The State itself seems to concede this point by not really answering it at all. See Pet. Brief, p. 26 (raising but not addressing the second test in *Turner v. Saflly*).

D. The Washington Supreme Court Correctly Assessed the Impact of Current Studies of Side Effects on the Outcome of This Case.

Once again, as other states have attempted to do in other right to refuse cases, the State and its supporting *amici* here try to minimize or deny altogether the ever-increasing evidence of the disabling -- even deadly -- side-effects from these drugs. See e.g., Pet. Brief, pp. 20-22. APA Brief, pp. 14-16, Washington CMHC Brief as Amicus Curiae, pp. 14-15. The sad thing about all of this continued denial and self-interested posturing is that these transparent claims are the best evidence against their perpetrators' claims of *Romeo* professionalism and expertise. From the beginning of these cases, the state hospital doctors have sought to explain away the patients' complaints through a series of fictions, by saying the side-effects were being "exaggerated", or that the side-effects were only "temporary" or perhaps most cynically, that the side-effects were the results of patients "faking". The reality, sadly, is quite the opposite of these fictions. Here, the Washington Supreme Court set out just one paragraph summarizing only some of the most commonly recognized side effects:

Also documented, however, are the adverse side-effects of anti-psychotic drug treatment. Less serious, reversible side effects include dystonia, a severe involuntary spasm of the upper body, throat, tongue or eyes; akathisia, the inability to remain still, restlessness and agitation; and pseudo-Parkinsonism, manifested by a mask-like face, drooling, muscle rigidity, stiffness, tremors and a shuffling gait. See finding of fact 9, Clerk's Papers, at 11; Kemna, *Current Status of Institutionalized Mental Health Patients' Right to Refuse Psychotropic Drugs*, 6 J. Legal Med. 107, 111-113 (1985); Goodman & Gilman's, at 164-72. Although common, these effects can be controlled by administration of other drugs, adjustment of the dosage, or termination of the therapy. Kemna, at 112; Goodman & Gilman's, at 164-72. Severe and potentially permanent

is tardive dyskinesia, an irreversible neurological disorder characterized by involuntary, uncontrollable movements of the tongue, mouth or jaw. Fingers, arms and legs may also be affected. Tardive dyskinesia can be masked by the drug causing the condition, and can manifest itself years after treatment has occurred. *Harper*, 107 Wn. 2d above at 887-8.

The plain fact, however, is that this list is merely the *beginning* of the painful, disfiguring and disabling side-effects that have been, and are increasingly becoming well "documented". Compare the *Harper* list above with the list of side effects in *Riese v. St. Mary's Hospital and Medical Center*, 196 Cal. App. 3d 1388, 243 Cal. Rptr. 241, at 244 (1987). Despite these well documented-disabling side-effects, however, the APA continues to rely on its outdated Task Force Report 18 on Tardive Dyskinesia published almost 10 years ago. See APA Brief, p. 14. In more current cases such as *Riese* above, *Jarvis v. Levine*, 418 N.W. 2d 139 (Minn. 1988), *Jones v. Gerhartslein* above, and *Rivers v. Katz*, 67 N.Y. 2d 485, 495 N.E. 2d 337, 504 N.Y.S. 2d 74 (1986), the patients and their *amici* have submitted not only follow-up studies challenging these outdated studies and statistics on tardive dyskinesia, neuroleptic malignant syndrome and other long established health risks but also significantly adding to the courts' sources for research and to the identification of the new side-effects presented to the courts.¹⁰ See, e.g., *Riese*, 243 Cal. Rptr. above, at 244 (regarding new research from pharmaceutical sources and new research on previously unknown side-effects).¹¹ For this brief,

¹⁰ For a more complete list of these "right to refuse" cases, with their own lists of side-effects, see the Brief of the United States as *amicus curae*, pp. 12-13, n. 21.

¹¹ See, e.g., Descotes, Tedone and Evreux, "Different Effects of Psychotropic Drugs on Delayed Hypersensitivity Responses in Mice", 12 *Journ. of Neuro-Immunology* 81 (1985); Jones, Van de Carr, Zimmerman and LeRoy, "Hepatotoxicity Associated with Phenothiazines", 19 *Psychopharm. Bull.* 27 (1983); Risch, Groom and Janowsky, "The Effects of Psychotropic Drugs on the Cardiovascular System," 43 *J. Clin. Psych.* 16 (1982); Laakman, William, Gugath, Mueller, Treusch, Wahlster and Stella, "Effects of psychotropic drugs on the human HPA axis", 84 *Psycharmacology* 66, (1984); and Ananth, Edelmuth and Dorjan, "Meiger's Syndrome Associated with Neuroleptic Treatment", 145 *Am. J. of Psych.* 4 (April 1988).

the current journals were again reviewed with the result that even more new research was identified and additional concerns added to the above, already reported "lists" of potential side-effects from these drugs. See, e.g., Lathers and Lipka, "Cardiac Arrhythmia, Sudden Death, and Psychoactive Agents", 27 *J. Clin. Pharmac.* 1 (1987); Bower, "When Antipsychotic Drugs Can Be Lethal", 130 *Sci. News* 260 (Oct. 1986); Van Putten and Marder, "Behavioral Toxicity of Antipsychotic Drugs", 48 *J. of Clin. Psych.* 13 (1987); Weiden, Mann, Haas, Mattson, and Frances, "Clinical Nonrecognition of Neuroleptic-Induced Movement Disorders: A Cautionary Study", 144 *Am. J. Psych.* 1148 (Sept. 1987); Antelman, "Time Dependent Sensitization As the Cornerstone for a New Approach to Pharmacotherapy: Drugs as Foreign Stressful Stimuli," 14 *Drug. Dev. Res.* 1 (1988); Antelman, Kocan, Edwards, Knopf, Perel and Stiller, "Behavioral Effects of a Single Neuroleptic Treatment Grow with the Passage of Time", 385 *Brain Research* 58 (1986); Gold and Justino, "'Bicycle Kickstand' Phenomenon: Prolonged Erections Associated With Antipsychotic Agents", 81 *South. Med. J.* 792 (June 1988); Steen and Ramsay-Goldman, "Phenothiazine-Induced Systemic Lupus Erythematosus with Superior Vena Cava Syndrome", 31 *Arthritis and Rheumatism* 923 (July 1985); Herrera, Sramek, Costa, Roy, Heh and Nguyen, "High Potency Neuroleptics and Violence in Schizophrenics", 176 *J. of Nerv. and Ment. Dis.* 558 (1988). Given these new studies revealing still more data on new side-effects -- plus other courts' extensive "lists" -- the *Harper* court clearly erred on the side of caution with its analysis of this issue and the judicially overseen "right to refuse" procedures.

E. Despite the State's and Its Amici's Claims, the Judicially Overseen Right to Refuse is Both Necessary and Cost-Effective.

At the most mundane level, the State claims -- as defendants have done since *Rennie* and *Rogers* -- that the judicial "right to refuse" procedure is not needed or cost-effective. As with the side-effects "fictions" already described above, the reality of right to refuse procedures -- some of which have now been in effect for years -- completely belies the administrative and fiscal nightmare claims of the State and its *amici* here.

For the record, the principal studies -- both pro and con -- include the following articles and monographs: Appelbaum and Gutheil, "Drug Refusal: A Study of Psychiatric Inpatients", 137 *Am. J. Psych.* 340 (1980); Appelbaum and Hoge, "Empirical research on the effects of legal policy on the right to refuse treatment" in Rappaport, Parry, "The Right to Refuse Treatment" *ABA Comm. on Ment. Dis.* (1986); Hoge and Kaplan, "The Right to Refuse Treatment under *Rogers v. Commissioner*: preliminary empirical findings and comparisons", 15 *Bull. of Amer. Acad. of Psych. & Law* 163 (1987); Cowmos, McKinnon and Adams, "A comparison of clinical and judicial procedures for reviewing requests for involuntary medication in New York," 34 *Hosp. & Comm. Psych.* 851 (1988); Hargreaves, Shumway, Knutsen, Weinstein and Senter, "Effects of the Jami-son-Farabee consent decree: due process protection for the involuntary psychiatric patients treated with psychoactive medication" 144 *Am. J. Psych.* 188 (1988); Bloom, Faulkner, Holm and Rawlinson, "An Empirical View of Patients Exercising Their Right to Refuse Treatment", 7 *Int'l. Jour. of Law and Psych.* 315 (1984); Zito, Hendel, Mitchell and Routh, "Drug treatment refusal, diagnosis, and length of hospitalization in involuntary psychiatric patients," 4 *Beh. Sci. and the Law* 227 (1986); Veliz and James, "Medicine Court: *Rogers* in Practice", 144 *Am. J. Psych.* 62 (1987).

The overwhelming consensus from these studies is perhaps best summarized by this comment from the Guidelines on In-voluntary Civil Commitment by the National Center for State Courts (hereinafter "Guidelines"):

Most involuntary patients accept care and treatment. Only one out of ten refuses treatment, usually the administration of psychotropic drugs. Guidelines, p. 38, 10 A.B.A. Ment. & Phys. Dis. L. R. 409 at 458 (Sept-Oct, 1986).

Significantly, the National Task Force responsible for the creation of the Guidelines included representatives from the amici APA, among them Dr. Paul Appelbaum, a leading critic and researcher on the right to refuse. See Guidelines, 10 A.B.A. Ment. Phys. Dis. L. R. above, at 409.

Here, despite this research, the same tired claims of *Parham* style "procedural minuets" are again being made against the judicially overseen right to refuse procedures. Pet. Brief p. 29 APA Brief, pp. 26-27¹².

From the very beginning of the state law based "right to refuse" in *Rogers v. Commissioner* 396 Mass. 489, 458 N.E. 2d 308 (1983), there has been a constant debate about the necessity and cost-effectiveness of external or judicial oversight of the refusal appeal process. In this Court and elsewhere, the *Rennie* plaintiffs demonstrated that without an external independent review, the "paper" procedures of the state Administrative Bulletin 78-3 were worthless to patients. See n. 2 above. See also *Mills v. Rogers*, 454 U.S. 1136, 102 S. Ct. 990 (1981) (New Jersey Public Advocate Motion for Leave to File Brief *Amicus Curae* Out of Time and Brief *Amicus Curae*), and *Rogers v. Commissioner*, 396 Mass., above, New Jersey Public Advocate Motions for Leave to File and Brief *Amicus Curae*, p. 5 ("The now realized conflicts of interest inherent in permitting state hospital administrators to review their staff doctors were earlier accurately described and predicted by the trial judge and the dissent on appeal in *Rennie*, ... Without the critical variable of required external review, the patients' right to refuse medication is merely an illusory right without a remedy.") The *Harper* SOC procedures are manifestly internal

¹² The principal study now relied upon in the APA brief is an unpublished "DMH memo" reporting anomalous results produced by the unsuccessful state defendants in *Mills v. Rogers* with no clear indication of either when the study was done or what the total number of surveyed patients, original refusals and negotiated settlements were. See APA Brief, p. 27. No other published, independently verified statistics are consistent with the "DMH memo".

procedures only with no provision for a regular external review. See *Harper*, 110 Wash. 2d above, at 879. Based on the *Rennie* experience before, during and after the district court, original 3rd Circuit and remand opinions, this conflict ridden process cannot police itself. See N.J. Public Advocate Brief *Amicus Curae* in *Rogers v. Commissioner*, 396 Mass., above.

The final bastion for Washington State and its *amici* is a strict dollars and cents approach to the "right to refuse".¹³ See e.g., Pet. Brief, p. 27 (list of potential costs) and APA Amicus Brief, p. 27 (costs in *Rogers* derived from unpublished "DMH memo").¹⁴ What the State and its *amici* fail to recognize or to mention at all is that the final "value" of the judicial overseen right to refuse process may not be a strictly quantifiable "box score" of the results or costs of final appeals of refusals. As Professor Alexander Brooks has noted: "A major accomplishment of refusal litigation seems to be heuristic." Brooks, "The Right to Refuse Antipsychotic Medication: Law and Policy," 39 *Rutgers L. R.* 339, 376 (1987). There can be no real measure of the unrecorded compromises between doctors and patients about which drug or which level can be agreed upon rather than either forced or refused. In the *Rennie* case, District Judge Stanley Brotman predicted just this result of a truly independent, external review of the "right to refuse":

(T)he number of cases reaching an independent decision-maker would eventually drop to a relatively small number of disputes. *Rennie*, 476 F. Supp. above, at 1306.

¹³ Washington's Mental Health Division has in fact projected only \$500,000 for costs related to "*Harper's Decision*". Wash. State Ment. H. Div., *Ment. Health Bull.*, June 6, 1989, p. 3.

¹⁴ By way of contrast between Massachusetts' experience in *Rogers*, at least as reported by the "DMH memo", and other states' right to refuse procedures, experienced mental health advocates from several other states have submitted affidavits with this Brief, confirming the lack of problems with their procedures. See, e.g., Affidavits of Milo Gray, Jr., Esq. (Indiana); Ava Crow, Esq. (Kentucky); William Brooks, Esq. (New York); Tannis L. Fox, Esq. (Arizona) and Dale K. Mattice (Hawaii); Appendices B, C, D, E and F, respectively, attached hereto.

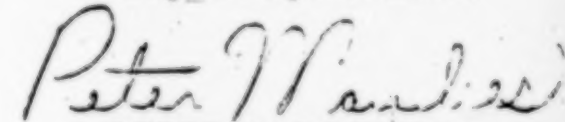
In its Motion and Proposed Brief *Amicus Curae* to this Court in *Mills v. Rogers*, above, the New Jersey Public Advocate -- the *Rennie* counsel -- submitted an Affidavit and Computer Chart showing that over a full year of the *Rennie* external review process the number of "contested" refusals steadily dropped. See Appendix "C" to the New Jersey Public Advocate Motion and Proposed Brief. Recently, other researchers on the right to refuse have documented the lower medication dosages given to refusers as opposed to "consenters", suggesting that doctor/patient negotiations were indeed occurring. See Zito, Hendel, Mitchell and Routt, "Drug Treatment Refusal, diagnosis and length of hospitalization in involuntary psychiatric patients," 4 *Beh. Sci. and the Law* 327 (1986). See also, regarding the actual results of right to refuse procedures in states across the country, the Affidavits lodged herewith as Appendices B,C,D, E and F. This all demonstrates that the bottom line for "right to refuse" procedures cannot be calculated by examining only the very end of the appeals process, just as appeals would hardly reflect the total results in other legal procedures, civil and criminal¹⁵.

¹⁵ Another unquantifiable factor is the "value" of the harm avoided by "right to refuse" procedures. One approach to such a valuation is the steady stream of damage actions involving psychotropic drugging which continue to emerge across the country. See, e.g., *Clites v. Iowa*, 322 N.W. 2d 917 (Ia. Ct. App. 1982) (\$760,165 verdict); *Estate of Verenna v. Comm. of Pa.*, C.P. Lehigh Co., Pa., Doc. No. 82-C-4486 (June, 1985) (\$115,000 settlement); *Hedin v. United States*, 9 A.B.A. Ment. & Phys. Dis. L. R. 130 (1985) (\$2,162,542 verdict); *Sibley v. Bd. of Super. L.S.U.*, 462 So. 2d 149 (La. 1985), 477 So. 2d 1094 (La. 1986), on remand 490 So. 2d 307 (La. Ct. App. 1986) (\$500,000 damages, statutory maximum); *Faigenbaum v. Oakland Medical Center*, 373 N.W. 2d 161 (Mich. App Ct. 1985) (\$1,000,000 verdict reversed on governmental immunity grounds). See also, *Barclay v. Campbell*, 704 S.W. 2d 8 (Tex. Sup. Ct. 1986) (remanded to trial court on the issue of informed consent); *Stone v. Smith, Kline & French*, 731 F. 2d 1575 (11th Cir. 1985) (Thorazine as "an unavoidably unsafe product"); *Johnson v. Silvers*, 742 F. 2d 823 (4th Cir. 1984) (remanded to trial court on the issue of damages) and *Walters v. Western State Hospital*, 864 F. 2d 695 (10th Cir. 1988) (interlocutory appeal on denial of summary judgement for defendant professional).

IV. CONCLUSION

For the reasons stated above, this Court should (1) dismiss the writ of certiorari in this case as improvidently granted based on the enactment of the state "right to refuse" law or (2) amend or narrowly construe the "Questions Presented" to focus only on the second question.

Respectfully submitted,



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